Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38501

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen Irene Boehm

2. Date of Death — Month: NOV Day: 13 Year: 2001

3. Time of Death: 745P

4a. Facility Name *(If not institution, give street and number)*: Mariner Health of Bel Air

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 213-20-9394

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: October 8, 1925

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 703 High Plain Drive

10f. Zip Code: 21014

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 years — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: personal manager

16b. Kind of Business/Industry: investments

17. Father's Name *(First, Middle, Last)*: John Edward Chrysam

18. Mother's Name *(First, Middle, Maiden Surname)*: Helen Klein

19a. Informant's Name/Relationship *(Type, Print)*: Victor L. Boehm, Jr./son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 702 Maple Hurst Lane, Monkton, Md. 21111-1427

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Moreland Memorial Park

Date: 11/17/01

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Amanda David

22. Name and Address of Facility: Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive Heart Failure	1week
Due to (or as a consequence of):	b. Renal Failure	3 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Type II Diabetics	20 years
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature end title of certifier: MD

29c. License number: D34652

29d. Date signed *(Month, Day, Year)*: November 14, 2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Scott Haswell 2 North Avenue Bel Air Maryland 21014

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 16 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Boehm, Helen

24

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38502

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Amelia Esther Bissell

2. Date of Death (Month, Dey, Year): November 13, 2001

3. Time of Death: 1750

4a. Facility Name *(If not institution, give street and number)*: Upper Chesapeake Medical Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 217-09-4814

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 4, 1920

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1117D Vanguard Way

10f. Zip Code: 21015

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Clerk

16b. Kind of Business/Industry: Retail Sales Store

17. Father's Name *(First, Middle, Last)*: Adolph (NMN) Hipley

18. Mother's Name *(First, Middle, Maiden Surname)*: Mattie Amelia Pearce

19a. Informant's Name/Relationship *(Type, Print)*: V. Rosalie Brandow/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1117D Vanguardway, Bel Air, MD 21015

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Fork UM Church | Date: 11-17-01

20c. Location - City or Town, State: Fork, Maryland

21. Signature of Funeral Service Licensee: Shirley A. Hughes

22. Name and Address of Facility: McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, MD 21014

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. metastatic cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David S. Dunn

29c. License number: D32279

29d. Date signed *(Month, Day, Year)*: November 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID S. DUNN (15 W. Mo. Phy.)

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 16 2001

32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

BISSELL, AMELIA

DHMH 16 Rev 6/95

ORIGINAL

01-6376-510
Ashley Blythe
mnmr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38503

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ashley Laurel Blythe	November 11, 2001	1130am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Shock Trauma	Baltimore	N/A

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
410-53-5124	1☐M 2☒F	17 Yrs.			Feb. 7, 1984	Tennessee

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Bel Air	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
209 Foxhall Drive, Apt. K	21015	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Student	High School

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Richard Powell Blythe	Catherine Morina Hippchen

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Richard P. Blythe/ Father	209 Foxhall Dr., Apt. K, Bel Air, MD 21015

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify)	Memorial Park Southwoods Cem.	11-17-01	Memphis, Tennessee

21. Signature of Funeral Service Licensee

22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Head injuries	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☒Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	11-10-2001	0545 AM	1☐Yes 2☒No	Subject was passenger in automobile involved in a collision

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
street	Route 23 Harford County, Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Stephen S. Radentz, M.D.	O.C.M.E.	NOVEMBER 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 16 2001	Penny D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38504

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wilhelmine Brands
2. Date of Death (Month, Day, Year): November 18, 2001
3. Time of Death: 12:18AM
4a. Facility Name (If not institution, give street and number): St. Agnes Nursing & Rehabilitation
4b. City, Town, or Location of Death: Ellicott City
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 068-34-0868
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 93 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 8, 1908
9. Birthplace (State or Foreign Country): Germany

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 3000 North Ridge Road
10f. Zip Code: 21042
10g. Citizen of What Country?: United States
11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Childcare Provider
16b. Kind of Business/Industry: Childcare
17. Father's Name (First, Middle, Last): Wilhelm Paetzold
18. Mother's Name (First, Middle, Maiden Surname): Anna Sachser
19a. Informant's Name/Relationship (Type, Print): Robert Brands/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5122 West Running Brook Columbia, Maryland 21044
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Long Island Nat'l Cem.
Date: 11/21/2001
20c. Location - City or Town, State: Long Island, New York
21. Signature of Funeral Service Licensee: [signature]
M011042
22. Name and Address of Facility: Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. DEMENTIA — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Congestive Heart Failure.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D42680
29d. Date signed (Month, Day, Year): Nov. 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Faba Sheikh 9051 BALTIMORE NATIONAL PIKE STE 4C ELLICOTT CITY MD 21042

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001
32. Registrar's Signature: [signature] D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No: 2001 38505

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
EVA	CARLI	NOV 15 2001	4:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LAUREL REGIONAL HOSPITAL	Laurel	PG

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
543-30-2778	1☐M 2☒F	89 Yrs.			09 30 1912	Oregon

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George	Laurel	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8802 Enfield Court	20708	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Secretary	Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ben Rosenbloom	Lena Ginsberg

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Stewart H. Flax/Son	1810 North 107 E101 Seattle, Washington 98133

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metropolitan Crem.	11/17/2001	Alexandria, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature] M01103	Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): URINARY TRACT INFECTION
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fatal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CARDIOMYOPATHY
CHRONIC ATRIAL FIBRILLATION
ALZHEIMER'S DEMENTIA

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	NA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
NA	

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D45217	11/17/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ADEBOWALE AJAYI MD 6201 GREENBELT RD U15 COLLEGE PARK MD 2940

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(8)

Cof

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38506

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Doris L. Combs

2. Date of Death Month: Nov. Day: 22, Year: 2001

3. Time of Death: 7:40A M

4a. Facility Name *(If not institution, give street and number)*: Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 220-56-0165

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 18, 1934

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 2425 Sunset Farm Road

10f. Zip Code: 21042

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

18b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Howard Martin, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Irene Howes

19a. Informant's Name/Relationship *(Type, Print)*: Sharon Lilley/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11895 Route 216 Fulton, Maryland 20759

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lakeview Cemetery

Date: 11/26/2001

20c. Location - City or Town, State: Sykesville, Maryland

21. Signature of Funeral Service Licensee: [signature] M01142

22. Name and Address of Facility: Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia — minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease — years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other *(specify)* 9☐Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Adrenal insufficiency

Hemiparesis 2° Ruptured Cerebral Aneurysm

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] W. Andrew Marks MD

29c. License number: D31205

29d. Date signed *(Month, Day, Year)*: November 23, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. ANDREW MARKS 2 KNOLL NORTH DR. COLUMBIA MD 21045

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 26 2001

32. Registrar's Signature: [signature] Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

9

Cof

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38507

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Frederick C. Cooper, Jr.	Nov. 23, 2001	07:50 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Howard County General Hospital	Columbia	Howard

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
039-12-8297	1 [X] M 2 [ ] F	74 Yrs.			Apr. 3, 1927	Rhode Island

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
R I	Newport	Middletown	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13 Fairview Avenue	02842	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Printing Estimator	Gen. Offset Printing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Frederick C. Cooper, Sr.	Katherine Jarvis

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Anne Cooper/Wife	13 Fairview Avenue Middletown. Rhode Island 02842

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	All County Crematory	11/24/2001	Sykesville, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
M01142	Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac Arrhythmia	seconds
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Atherosclerotic Cardiovascular Disease	21 years
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown	23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

MI 1979, Coronary By-pass Grafts 1980, (B) + (C) iliac artery surgery 1998, prostate surgery 1997

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [X] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Patryce A. Toye MD Deputy ME	D31473	Nov. 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRYCE A. TOYE, MD 4565 Hemlock Cove Way Ellicott City MD 21042

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 26 2001	G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 38508

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Morris Russell Collins

2. Date of Death Month / Day / Year: November 26, 2001

3. Time of Death: 10:10 am

4a. Facility Name *(If not institution, give street and number)*: Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 516-10-3820

6. Sex: 1☐M 2☐F — XX

7. Age *(In yrs. last birthday)*: 92 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Oct 21, 1909

9. Birthplace *(State or Foreign Country)*: Missouri

Usual Rasidence of Decedent

10a. Stata: MD

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐Yes 2☒No X

10e. Street and Number: 10433 Waterfowl Court

10f. Zip Code: 21044

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐Nevar Married 2☐Married 3☒Widowed X 4☐Divorced

12. Was Decedant Ever in U.S. Armed Forcas? 1☒Yas 2☐No — If Yas, Giva Yaar or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐Yes 2☒No X *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4 years

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Analyst

16b. Kind of Businass/Industry: U.S. Government

17. Fathar's Nama *(First, Middle, Last)*: Elmer E. Collins

18. Mother's Neme *(First, Middle, Maiden Surname)*: Elsie Russell

19a. Informant's Name/Ralationship *(Type, Print)*: Robert Collins / son

19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4908 Fleming Road Mt. Airy, Maryland 21771

20a. Mathod of Disposition: 1☒Burial X 2☐Cremation 3☐Removal from Stata 4☐Donation 5☐Othar *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other placa)*: Savage Cemetery

Data: Nov 30 2001

20c. Location - City or Town, Stata: Savage, Maryland

21. Signature of Funaral Service Licensee: [signature] / M00770

22. Nama and Addrass of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part I. Ente the disease, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart tailura. List only ona cause on aach lina.

Approximata Intarval Between Onsat and Death

Immediata Causa (Final disaasa or condition resulting in death)

a. Pneumonia — 2 weeks

Dua to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last

b.

Dua to (or as a consequance of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☑No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐Yas 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death *(Check only one)*: Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicida 5☐Pending Investigation 6☐Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Describe how injury occurred

28e. Placa of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Cartifiar *(Check only one)*: 1☑**Certifying Physician:** To tha best of my knowledga, daath occurred at the time, date and placa, and dua to tha causa(s) and mannar as stated. 2☐**Medical Examiner:** On tha basis of examinetion and/or investigation, in my opinion, deeth occurred at the tima, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. Licensa number: D51963

29d. Data signed *(Month, Day, Year)*: NOV 28, 2001

30. Name and addrass of person who completed causa of daath (Item 23a) (Type, Print): JONATHAN FISH MD 7460 ELLICOTT CTR DR #103 ELLICOTT CITY MD 21043

State Registrar

31. Data filed *(Month, Day, Year)*: NOV 30 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

20

CJF

Please Type or Print In Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38509

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bernice Maxine Carvell

2. Deta of Deeth — Month: November — Day: 11, 2001 — Yaar:

3. Time of Death: 0817

4a. Facility Neme *(If not institution, giva street and number)*: Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Deeth: Carroll

Funeral Director

5. Social Security Number: 233-56-5096

6. Sex: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 64 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 30 1937

9. Birthplece *(Stete or Foreign Country)*: West Virginia

Usuel Residenca of Decedent

10a. Stete: Maryland

10b. County: Carroll

10c. City, Town or Location: Sykesville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6556 MacBeth Way

10f. Zip Code: 21784

10g. Citizen of Whet Country?: United States

11. Maritel Status: 1☐ Nevar Marriad 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No — If Yes, Giva Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puerto Ricen, etc.) 1☐ Yas 2☒ No *Specify:*

14. Rece - Amarican Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grade completed)*: Elementery/Secondery (0-12): 12th — College (1-4or 5+):

16e. Decedent's Usuel Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Receptionist

18b. Kind of Business/Industry: Carmax

17. Fether's Neme *(First, Middle, Last)*: Ernest Thompson

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Audra Burdette

19a. Informent's Name/Reletionship *(Type, Print)*: Maxine Hagy Daughter

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1898 Rockridge Ct. Marriottsville, MD 21104

20e. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☒ Ramovel from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Evergreen Cemetery — Date: Nov. 16 2001

20c. Location - City or Town, State: Parkersburg, West Virginia

21. Signeture of Funerel Service Licensee: James B Craig

22. Name end Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Sykesville, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the diseesa, or compiications thet caused the deeth. Do not enter the mode of dying, such es cardiac or raspiretory errest, shock, or heart feilure. List only one ceuse *on* each line.

Approximate Intervel Batween Onsat and Death

Immadiate Ceusa (Final disease or condition resulting in death) — e. Atherosclerotic Coronary artery disease — years

Due to (or es e consequence of):

Sequentiaily iist conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Last

b. Due to (or es a consequence of):

c. Due to (or es e consequenca of):

d.

Pert tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.: Diabetes; Lung Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to compiation of ceusa of death? 1☒ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Mennar of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, straat, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end piece, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred at the time, date end placa, and due to the ceuse(s) and menner steted.

29b. Signeture and title of certifier: [signature] MD

29c. Licensa number: D44362

29d. Data signed *(Month, Day, Year)*: Nov 12, 2001

30. Name end eddrass of person who completed ceuse of death (Item 23a) (Type, Print): Enrico A. Giangeruso, MD — 200 Memorial Ave, Westminster, MD 21157 — Carroll County Gen. Hosp.

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 16 2001

32. Registrar's Signeture: Donna B Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

WJL 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 38510

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Margaret Lee Chambers	Nov. 15, 2001	1905 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Upper Chesapeake Medical Center	Bel Air	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-01-3219	1☐M 2☒F	88 Yrs.			Aug.16,1913	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Fallston	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2608 Harford Road	21047	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	1	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Harry Lee Smith	Bertha Irene Williams

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Thomas R. Chambers, Jr./Son	2608 Harford Road, Fallston, MD 21047

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Bel Air Mem. Gardens	11-20-01	Bel Air, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Stephen A Krueger	McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, MD 21014

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arrhythmia	3 days.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as e consequence of): c.	
	Due to (or as e consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Sick Sinus Syndrome.

Osteoporosis.

Adult Onset Diabetes Mellitus

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D35012	November 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Kevin Lynch MD 2 North Ave. Bel Air, Md. 21014

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	▶ Jenna G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MARGARET L. Chambers dm 10

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 38511

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Greer Cox

2. Date of Death — Month: NOV Day: 14 Year: 2001

3. Time of Death: 4:30 AM

4a. Facility Name *(If not institution, give street and number)*: MARINER HEALTH - BEL AIR

4b. City, Town, or Location of Death: BEL AIR

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 217-07-7413

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 22, 1915

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 1009 James Street

10f. Zip Code: 21014

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Warehouseman

16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: Charles Cleveland Cox

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Anna Sexton

19a. Informant's Name/Relationship *(Type, Print)*: Dennis M. Scarborough / Brother In-Law

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1009 James St., Bel Air, MD 21014

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other *(Specify)*: Entombment

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bel Air Memorial Grdns

Date: 11-19-01

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: McComas Funeral Home, P.A. 50 West Broadway, Bel Air, Maryland 21014

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. congestive heart failure — 4 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: prostate cancer; anemia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David S. Dunn

29c. License number: D32279

29d. Date signed *(Month, Day, Year)*: November 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID S. DUNN 615 W. MAIN

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 19 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

William Cox

8+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38512

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BETTY JEAN COMBS

2. Date of Death — Month: NOV Day: 16 Year: 2001

3. Time of Death: 5:25pm

4a. Facility Name *(If not institution, give street and number)*: Mariner Health Bel Air

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: HARFord

Funeral Director

5. Social Security Number: 215-80-0136

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 59 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 1, 1942

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 410 E. McPhail Rd

10f. Zip Code: 21014

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 0 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: never employed

16b. Kind of Business/Industry:

17. Father's Name *(First, Middle, Last)*: Roy E. Combs

18. Mother's Name *(First, Middle, Maiden Surname)*: Hattie Rhudy

19a. Informant's Name/Relationship *(Type, Print)*: Joyce A. Combs- sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2049 Glen Cove Road, Darlington, MD 21034

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Darlington Cemetery

Date: 11/19/01

20c. Location - City or Town, State: Darlington, MD

21. Signature of Funeral Service Licensee: John H. Tillett

22. Name and Address of Facility: Harkins F.H. Inc., 600 Main St., Delta, PA 17314

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — 1 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: JR MD

29c. License number: D34652

29d. Date signed *(Month, Day, Year)*: November 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scott Haswell 2 North Avenue Bel Air, Maryland 21014

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 19 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Combs, Betty Jean

Amend Item #18, Per F.D. 11/19/2001, Carroll County, cew

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38513

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Wesley Dawkins, Jr.

2. Date of Death (Month, Day, Year): November 16 2001

3. Time of Death: 10:05 P.M.

4a. Facility Name (If not institution, give street and number): Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 217-20-3052

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 13, 1926

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 1111 Deer Park Road

10f. Zip Code: 21157

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No. If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Business/Industry: Social Security Administration

17. Father's Name (First, Middle, Last): George Wesley Dawkins, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Alice A. Dickson

19a. Informant's Name/Relationship (Type, Print): Stuart Dawkins - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1111 Deer Park Road Westminster, MD 21157

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Park

Date: Nov. 24, 2001

20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: James B Camp

22. Name and Address of Facility: Burrier-Queen Funeral Directors, 1212 W. Old Liberty Rd. Winfield, MD 21784

Physician /Medical Examiner

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Myocardial infarction	24hr
Due to (or as a consequence of): b.	ASCVD	15yr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Diabetes	15yr
Due to (or as a consequence of): d.	Liver disease	15yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John W. Middleton

29c. License number: D25443

29d. Date signed (Month, Day, Year): 11/17/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W. Middleton 688 Poole Rd. Westminster, MD 21157

State Registrar

31. Date filed (Month, Day, Year): NOV 19 2001

32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10+1V+

01-6545-013
B.K.S
KARL DAVID ELHERS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2001 38514

1- For State Registrar UNPENDED 121101: ITEMS#23a,27,28a-f per ME G802 ss

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
KARL DAVID EHLERS	NOV. 17, 2001	1010 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1359 STREAKER ROAD	SYKESVILLE	CARROLL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213 78 2185	1 [X] M 2 [ ] F	39 Yrs.			Sept 20, 1962	New Jersey

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Carroll	Sykesville	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1359 Streaker Road	21784	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Postal Carrier	US Postal Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Neal A. Ehlers	Jean M. Blaich

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jean B. Ehlers/Mother	9705 Cypressmede Drive Ellicott City, MD 21042

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	All County Crematory	11-21-2001	Sykesville, MD

21. Signature of Funeral Service Licensee		22. Name and Address of Facility
▶ Susan Collins - with the	M01044	Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARBON MONOXIDE INTOXICATION	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [X] Yes 2 [ ] No	1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 [X] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) AT SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	Found: 11-17-01	Found: 8:50a M	1 [ ] Yes 2 [X] No	Subject inhaled auto fumes
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence			28f. Location (Street and Number or Rural Route Number, City or Town, State) 1359 Streaker Rd., Sykesville, MD

29a. Certifier (Check only one)
1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Theodore M. King MD	O.C.M.E	NOV. 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	▶ P Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38515

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret Hallameyer Francis

2. Date of Death — Month: November Day: 8 Year: 2001

3. Time of Death: 9:15 pm

4a. Facility Name *(If not institution, give street and number)*: LORIEN @ RIVERSIDE

4b. City, Town, or Location of Death: BELCAMP

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 214-01-3451

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Apr. 14, 1915

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1024 Prospect Mill Road

10f. Zip Code: Bel Air

10g. Citizen of What Country?: USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 9; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Person

16b. Kind of Business/Industry: Retail Clothing Store

17. Father's Neme *(First, Middle, Last)*: Joseph (nmn) Hallameyer

18. Mother's Name *(First, Middle, Meiden Surneme)*: Marie (nmn) Freihammer

19a. Informent's Name/Relationship *(Type, Print)*: Carol Coleman / Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1024 Prospect Mill Road, Bel Air, MD 21015

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, crematory or other pleca)*: Hilltop Service Corp.

Date: 11-10-01

20c. Location - City or Town, State: Towson, Maryland

21. Signeture of Funerel Service Licensee: Holly McComas Penyton

22. Neme end Address of Feciliity: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death): a. Coronary Artery Disease — 75yrs

Due to (or as a consequenca of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest:

b.

Due to (or es a consequence of):

c.

Due to (or es a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Malnutrition Dehydration

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and pleca, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: MD

29c. License number: D 32606

29d. Dete signed *(Month, Dey, Year)*: 11/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kamrudin Mulla MD 1106 Revolution St Havre de Grace MD 21078

State Registrar

31. Date filed *(Month, Dey, Year)*: NOV 14 2001

32. Registrer's Signeture: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

MARGARET M. FRANCIS

dm

7

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38516

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANNA FRANCES GOVER
2. Date of Death Month Day Year: November 23, 2001
3. Time of Death: 6:36 pm
4a. Facility Name *(If not institution, give street and number)*: Gladys Spellman Nursing Home & Spec. Hosp.
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 216-40-5827
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 59 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 3, 1942
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12715 Claxton Drive
10f. Zip Code: 20708
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Graduate Secretary
16b. Kind of Business/Industry: University of Maryland

17. Father's Name *(First, Middle, Last)*: Joseph Longfellow
18. Mother's Name *(First, Middle, Maiden Surname)*: Lucia LePore

19a. Informant's Name/Relationship *(Type, Print)*: Howard Gover /spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12715 Claxton Drive, Laurel, Maryland 20708

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Mary's Cemetery — Date: 11/26/01
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: M00773
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Severe Chronic Obstructive Lung Disease	15 yrs
	Due to (or as a consequence of): Pneumonia	2 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Mycobacterium Avium Intracellulare

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: R Murthy
29c. License number: D16273 MD
29d. Date signed *(Month, Day, Year)*: 11/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): REVATHY MURTHY 6130 Landover Rd Cheverly MD

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 27 2001
32. Registrar's Signature: Brenda G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

15 dcd

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38517

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CECELIA ANN HANLIN
2. Date of Death (Month, Day, Year): NOVEMBER 12, 2001
3. Time of Death: 6:11 P. M

4a. Facility Name (If not institution, give street and number): MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 215-42-4836
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 60 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 14, 1941
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: WV
10b. County: MINERAL
10c. City, Town or Location: RIDGELEY
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: ROUTE 1, BOX 111
10f. Zip Code: 26753
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
18b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): ELMER LEASE
18. Mother's Name (First, Middle, Maiden Surname): BESSIE HART

19a. Informant's Name/Relationship (Type, Print): CHARLES H. HANLIN / HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): ROUTE 1, BOX 111 - RIDGELEY, WV 26753

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): POTOMAC MEMORIAL GDNS
Date: 11/16/2001
20c. Location - City or Town, State: KEYSER, WV

21. Signature of Funeral Service Licensee: Sherry D. Upchurch
22. Name and Address of Facility: UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Immediate Cause (Finel disease or condition resulting in death)
a. MYOCARDIAL INFARCTION — Approximate Interval Between Onset and Death: 1 HOUR

Sequentially list conditions, if any, laading to immediete ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. ISCHEMIC CARDIOMYOPATHY — 4 YEARS
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
DIABETES MELLITUS

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Cartifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: Paul J. Livengood MD
29c. License number: D23774
29d. Date signed (Month, Day, Year): NOVEMBER 16, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 912 SETON DR. Cumberland Md. 21502

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001
32. Registrar's Signature: Penny D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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MS

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38518

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William A. Hahn, Sr.

2. Date of Death: Month NOVEMBER Day 17th Year 2001

3. Time of Death: 5.15A. M

4a. Facility Name (If not institution, give street and number): Northwest Hospital

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-12-4053

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 13, 1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3142 Paulskirk Drive

10f. Zip Code: 21042

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Pharmacist

16b. Kind of Business/Industry: State of MD Drug Enfrcmt. Unit

17. Father's Name (First, Middle, Last): Albert G. Hahn

18. Mother's Name (First, Middle, Maiden Surname): Margaret F. Fox

19a. Informant's Name/Relationship (Type, Print): Mary Jane Hahn/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3142 Paulskirk Drive Ellicott City, MD 21042

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Crestlawn Mem. Gard.

Date: 11/20/2001

20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funeral Service Licensee: M011042

22. Name and Address of Facility: Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RECENT MYOCARDIAL INFARCTION — WEEKS

Due to (or as e consequence of):

b. CORONARY ARTERY DISEASE — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. ATHEROSCLEROSIS — YEARS

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARDIOMYOPATHY, CHRONIC OBSTRUCTIVE LUNG DISEASE, RENAL FAILURE, GASTRO INTESTINAL BLEEDING. CARDIAC ARRHYTHMIAS

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R Rangarajan . M.D

29c. License number: D54288

29d. Date signed (Month, Day, Year): November 17th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAMAMURTHY L RANGARAJAN . Northwest Hospital .

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

HAHN, WILLIAM

7+1

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38519

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Evelyn M. Haines
2. Date of Death (Month, Day, Year): November 18, 2001
3. Time of Death: 3:55 PM
4a. Facility Name (If not institution, give street and number): Look About Manor
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 219-20-0287
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 94 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 13, 1907
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Woodbine
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 7242 John Pickett Road
10f. Zip Code: 21797
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): General Employee
16b. Kind of Business/Industry: Rescue Mission

17. Father's Name (First, Middle, Last): Howard L. Bair
18. Mother's Name (First, Middle, Maiden Surname): Mamie Barnes

19a. Informant's Name/Relationship (Type, Print): Larry Haines - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 621 Meadow Branch Road Westminster, MD 21158

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Pleasant Ridge Cemetery
Date: Nov. 21, 2001
20c. Location - City or Town, State: Woodbine, Maryland

21. Signature of Funeral Service Licensee: ▶ Pam B Carey
22. Name and Address of Facility: Burrier-Queen Funeral Home 1212 W. Old Liberty Rd. Winfield, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute pulmonary edema
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. congestive heart failure
Due to (or as a consequence of):
c. ASCVD
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension.
Atrial fibrillation.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☑Other (Specify) Domiciliary Care Facility
27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Lesley MD
29c. License number: D33599
29d. Date signed (Month, Day, Year): 11/19/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Philip J. Ruzbarsky 125 Airport DR. Suite 34 Westminster, MD 21157

State Registrar

31. Date filed (Month, Day, Year): NOV 19 2001
32. Registrar's Signature: ▶ Donna B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CEW 6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38520

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances Louise Hill

2. Date of Death: Month: Nov Day: 16 Year: 2001

3. Time of Death: 1:55 PM

4a. Facility Name (If not institution, give street and number): MARINER HEALTH OF BELAIR

4b. City, Town, or Location of Death: BELAIR

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 212-28-5464

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 26, 1930

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1601 Sako Court

10f. Zip Code: 21015

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Robert u/k Fitch

18. Mother's Neme (First, Middle, Maiden Sumeme): Barbara E. Miedeck

19a. Informant's Name/Relationship (Type, Print): Bernard R. Hill- Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1602 Sako Court, Bel Air, Maryland 21015

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Neme of cemetery, cremetory or other piece): Ebenezer U.M. Cemetery

Date: 11/19/01

20c. Location - City or Town, State: Middle River, Maryland

21. Signature of Funeral Service Licensee: Holly McComas Penuto

22. Name and Address of Fecility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): e. Acute Myocardial Infarction — within two hours

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Due to (or as a consequenca of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure

Diabetes Mellitus Type II

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and piece, end due to the cause(s) and menner steted.

29b. Signature and title of certifier: Manuel MD

29c. License number: D19583

29d. Date signed (Month, Dey, Year): November 17, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): MANUEL M. LAZATIN MD 8 Law Street Aberdeen, Maryland 21001

State Registrar

31. Date filed (Month, Dey, Year): NOV 19 2001

32. Registrar's Signature: D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38521

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Janet M. Hubbard
2. Date of Death Month Day Year: November 14, 2001
3. Time of Death: 7:45 A M
4a. Facility Name (If not institution, give street and number): 4419 Wynn Road
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-36-0274
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 63 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 13, 1938
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 4419 Wynn Road
10f. Zip Code: 21236
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th Grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Ellsworth Brown
18. Mother's Name (First, Middle, Maiden Surname): Hilda Ansminck

19a. Informant's Name/Relationship (Type, Print): Mr. Edward Hubbard (husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4419 Wynn Road, Baltimore, MD 21236

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery
Date: 11/17/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Amanda David
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. glioblastoma — Due to (or as a consequence of): — one year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Thomas Kowalewski MD
29c. License number: D21022
29d. Date signed (Month, Day, Year): 11-15-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Th. KOWALEWSKI MD 7672 Bolton Rd Balto. MD. 21236

State Registrar

31. Date filed (Month, Day, Year): NOV 15 2001
32. Registrar's Signature: ▶ [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38522

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Cathy Racine Hinchy

2. Date of Death — Month: November Day: 10 Year: 2001

3. Time of Death: 18:39

4a. Facility Name *(If not institution, give street and number)*: Upper Chesapeake Medical Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 216-52-6182

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 51 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 18, 1950

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Darlington

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1616 Castleton Road

10f. Zip Code: 21034

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Administrator

16b. Kind of Business/Industry: Health Care

17. Father's Name *(First, Middle, Last)*: Beryl Stewart Miller, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Parice (nmn) Smoot

19a. Informant's Name/Relationship *(Type, Print)*: Gary J. Hinchy - Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1616 Castleton Road, Darlington, Maryland 21034

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Dublin Southern Cemetery

Date: 11-14-01

20c. Location - City or Town, State: Dublin, Maryland

21. Signature of Funeral Service Licensee: Charles A Emge Jr

22. Name and Address of Facility: McComas Funeral Home, P.A. 50 West Broadway, Bel Air, Maryland 21014

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. ASCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: DMG

29c. License number: OCME

29d. Date signed *(Month, Day, Year)*: Nov 10 2001

30. Name and address of person who completed cause of death (item 23a) (Type, Print): GS PRABHU MD 728 BELAIR RD #134 BELAIR MD 21014

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 16 2001

32. Registrar's Signature: Penny G Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38523

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JOAN MAY HILL	November 9, 2001	6:24 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Laurel Regional Hospital	Laurel	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-44-3152	1☐M 2☒F	67 Yrs.			November 18, 1933	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Charles	Bel Alton	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9630 Bel Alton Newtown Road	20611	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	1	Administrative Assistant	Federal Govt.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Herbert Franklin Sandy, Sr.	Athey Catherine Shannon Sandy

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20640
Judy McKeever/sister	5562 Chapmans Landing Rd. Indian Head, Md

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	St. Barnabas Church	11/14/01	Temple Hills, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
David A. Echols M00945	AREHART-ECHOLS FUNERAL HOME, P.A. P.O. BOX 567 LA PLATA, MD. 20646

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPTIC SHOCK.	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. RESPIRATORY FAILURE	
	Due to (or as a consequence of): c. CARDIAC FAILURE	
	Due to (or as a consequence of): d.	

P.G. 23A

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Suresh K. Ichetan	D55403	11/10/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SURESH K. ICHETAN, M.D., 7610 CARROLL AVE #260, TAKOMA PARK, MD 20912

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 13 2001	Geneva D. Spann

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified as soon.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended #26, mlo, 11/21/01, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38524

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Yeer	3. Time of Daath
George E. King	November 20, 2001	4:15 PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deeth	4c. County of Deeth
12800 New Row Road, N.W.	Mount Savage	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Undar 24 Hrs. Hours	Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplece (State or Foreign Country)
212-24-2269	1 [X] M 2 [ ] F	73 Yrs.					02-Sep-28	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Insida City Limits
Maryland	Allegany	Mount Savage	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizan of What Country?
15708 St. Patrick's Church Road, N.W.	21545-	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, Whita, atc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	0	carpenter	construction

17. Fether's Nama (First, Middle, Last)	18. Mothar's Nama (First, Middla, Maidan Sumama)
John King	Pearl Crowe

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda)		
Joan McCoy daughter	665 Cooks Mill Road	Hyndman	Pennsylvania 15545-

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Data	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Saint Patrick's Cemetery	23-Nov-01	Mount Savage, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Fecility
John R. Durst	Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediata Cause (Final disease or condition resulting in death)	a. Arteriosclerotic heart disease	uk yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at tima of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of causa of deeth?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)					
1 [X] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [X] Residence	6 [X] Othar (Specify) Daughter's Home			

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at tha time, dete and place, and dua to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurrad at tha tima, date and place, and dua to the causa(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
Paul Snow	D09157	Nov 21 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)
Paul Snow, M.D., 124 W. Third Street, Cumberland, Maryland 21502

State Registrar

31. Dete Filed (Month, Day, Year)	32. Registrar's Signature
NOV 21 2001	Penny D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

7

MLS

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38525

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Thelma Eileen Knouse	Nov. 15, 2001	8:05 p.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Greater Baltimore Medical Center	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-16-6029	1☐M 2☒F	82 Yrs.			Oct. 3, 1919	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Parkton	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
102 Mt. Carmel Road	21120	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Cafeteria Worker	Public Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harry Armacost	Grace Almony

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JoAnn Gray	88 Laurel Drive, Stewartstown, PA 17363

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Dulaney Valley Memorial Gardens	Nov. 19, 2001	Timonium, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Coronary Heart Disease	10 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Chronic Obstructive pulmonary Disease	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
R. Gallucci MD	D34122	11/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
R. Gallucci MD 10450 York Rd - Hunt Valley, MD.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	Geneva Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38526

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Marchel Kennard

2. Date of Death: Month Nov. Day 16, Year 2001

3. Time of Death: 15:06 P.M

4a. Facility Name (If not institution, give street end number): Garrett County Memorial Hospital

4b. City, Town, or Location of Death: Oakland

4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 236-17-5670

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): May 20, 1921

9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. State: WV

10b. County: Tucker

10c. City, Town or Location: Davis

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: Blackwater Ave.

10f. Zip Code: 26260

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armad Forcas? [X] Yes 2 [ ] No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): Truck Driver

16b. Kind of Business/Industry: Coal

17. Father's Name (First, Middle, Last): William Washington Kennard

18. Mother's Name (First, Middle, Maiden Sumame): Flora Dell Campbell

19a. Informant's Name/Relationship (Type, Print): Goldie Kennard/wife

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): P.O. Box 175 Davis, WV 26260

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Davis Cemetery | Dete: 11-19-01

20c. Location - City or Town, State: Davis, WV

21. Signature of Funeral Service Licensee: G. Scott Hinkle

22. Name and Address of Facility: Hinkle Funeral Home P.O. Box 186 Davis, WV 26260

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiretory arrest, shock, or heert feilure. List only one cause on eech line.

Approximate Intervel Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death)

a. chronic obstructive pulmonary disease — 4 yrs

Due to (or as e consequence of):

b. hx of Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performad? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings availeble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Piece of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and mannar stated.

29b. Signeture and title of certifier: Donald R Richter MD

29c. License number: D 30035

29d. Date signed (Month, Day, Year): 11/16/01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): DONALD R. RICHTER MD 1533 MEMORIAL DR OAKLAND MD 21550

State Registrar

31. Dale filed (Month, Dey, Yaer): DEC - 3 2001

32. Registrar's Signature: Pamela D Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

RJD
01-6646-025
ERNEST LAROSA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 011702: ITEMS#23a-ptI,II,27,28a-I per ME G803 ss

Certificate of Death

Reg. No. 2001 38527

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Ernest Bernard LaRosa, Jr.	NOVEMBER 22, 2001	0024A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
UPPER CHESAPEAKE MEDICAL CENTER	BELAIR	HARFORD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-52-6825	1☒M 2☐F	51 Yrs.			April 2, 1950	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Abingdon	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3712 Longley Road	21009	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Contractor	Contracting

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ernest Bernard LaRosa, Sr.	Sallie McVicker

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Barbara D. LaRosa (wife)	3712 Longley Road, Abingdon, Maryland 21009

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Cokesbury UM Cemetery	11/24/01	Abingdon, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kenneth B. Cargo,	Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrast, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Finel disease or condition resulting in death)	a. COCAINE INTOXICATION	
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or es a consequence of): c.	
	Due to (or es e consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at tima of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATHEROSCLEROTIC CARDIOVASCULR DISEASE

23e. Did tobacco use contribute to the ceuse of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1☒Yes 2☐No	1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined	Found: 11-21-01	Unknown M	1☐Yes 2☒No	Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Found at Residence	3712 Langley Rd., Abingdon, MD

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha causa(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	O.C.M.E.	NOVEMBER 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 0 3 2001	▶ Jennie P Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38528

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jarrett Walter Lyons, Jr.

2. Data of Death — Month: Nov. Day: 15 Yaar: 2001

3. Time of Death: 5:40pm

4a. Facility Nama *(If not institution, giva street and number)*: Citizens Nursing Home

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 236-32-8360

6. Sex: 1 [X] M 2 [ ] F

7. Aga *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Yaar — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Data of Birth *(Month, Day, Yaar)*: 11/23/1924

9. Birthplace *(Stata or Foreign Country)*: West Virginia

Usual Rasidance of Dacedant

10a. Stata: MD

10b. County: Harford

10c. City, Town or Location: Havre de Grace

10d. Insida City Limits: 1 [X] Yas 2 [ ] No

10e. Street and Number: 951 Nena Ave.

10f. Zip Coda: 21078

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Dacedant Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yas, Giva Yaar or Dates: 1943-45

13. Wes Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grade compiatad)*: Elementary/Secondary (0-12): Collega (1-4or 5+): 2 Years

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Civil Service

16b. Kind of Businass/Industry: Government

17. Fathar's Nama *(First, Middle, Last)*: Jarrett Walter Lyons, Sr.

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Isabelle Earls

19a. Informant's Name/Ralationship *(Type, Print)*: J. Louise Lyons- Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 951 Nena Ave., Havre de Grace, MD 21078

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Piece of Disposition *(Nama of cematary, cramatory or other place)*: R.A. Ferris & Co. Inc.

Data: 11/20/01

20c. Location - City or Town, Stata: West Chester, PA

21. Signatura of Funeral Servica Licansea: Lauraine M. Smith

22. Neme end Addrass of Facility: Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not entar the moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in death): a. Advanced Small Cell Carcinoma of Lung — 1 1/2 years

Sequentially list conditions, if eny, leading to immediate causa. Entar Underlying Causa (Disaasa or injury that initiated avants resulting in daath) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceusa givan in Part I.: Pancytopenia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performad? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings eveilabla prior to compiation of cause of daath? 1 [ ] Yas 2 [✓] No

25. Was case refarrad to medical examinar? 1 [ ] Yas 2 [✓] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [✓] Nursing Homa 5 [ ] Rasidance 6 [ ] Othar *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending Invastigation 6 [ ] Could not be determinad

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Dascribe how injury occurred

28a. Place of Injury - At home, ferm, street, factory, office building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifiar *(Check only one)*: 1 [✓] **Certifying Physician:** To tha best of my knowledge, death occurred at tha tima, data and piace, and dua to tha cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and piace, and dua to tha cause(s) and mannar stated.

29b. Signature end titla of certifiar: Manuel M. MD

29c. Licansa number: D19383

29d. Data signed *(Month, Day, Yaar)*: November 16, 2001

30. Nama and addrass of person who compiated ceusa of daath (Item 23a) (Type, Print): MANUEL M. VAZATN MD 8 Law Street Aberdeen Maryland 21001

State Registrar

31. Data filed *(Month, Day, Yaar)*: NOV 19 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours aftar death.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiana.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Lyons, Jarratt

12th

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38529

GERARD MARTIN 100-05-2464

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gerard T. Martin
2. Date of Death (Month, Day, Year): NOVEMBER 18, 2001
3. Time of Death: 11:40 AM
4a. Facility Name (If not institution, give street and number): MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 100-05-2464
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jun 10, 1906
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 13 Blackiston Avenue
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): steamfitter
16b. Kind of Business/Industry: Textile
17. Father's Name (First, Middle, Last): William Thomas Martin
18. Mother's Name (First, Middle, Maiden Surname): Lucy C Dressman
19a. Informant's Name/Relationship (Type, Print): Mary Martin daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13 Blackiston Avenue; Cumberland MD 21502
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Mary's Cemetery
Date: 11/21 2001
20c. Location - City or Town, State: Cumberland, MD
21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease — Unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renal Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert Welik
29c. License number: D31875
29d. Date signed (Month, Day, Year): November 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Robert Welik, 902 Seton Drive, Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001
32. Registrar's Signature: Donna G Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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DHMH 16 Rev 6/95

ORIGINAL

Amended #9, mls, 11/20/01, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38530

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FLORENCE KATHLEEN MAY
2. Date of Death: Month NOV Day 17 Year 2001
3. Time of Death: 9:15 PM
4a. Facility Name (If not institution, give street and number): 520 EASTERN AVE.
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 089-40-4092
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 53 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC 11, 1947
9. Birthplace (State or Foreign Country): MASSACHUSETTS

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: CUMBERLAND
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 520 EASTERN AVE.
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1966-1969
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSE
16b. Kind of Business/Industry: MEDICAL

17. Father's Name (First, Middle, Last): JASPER C. SNYDER
18. Mother's Name (First, Middle, Meiden Surname): RUTH A. INGALLS

19a. Informant's Name/Relationship (Type, Print): JAMES C.MAY - HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 520 EASTERN AVE., CUMBERLAND, MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): SUNSET MEMORIAL PARK
Date: NOV 21, 2001
20c. Location - City or Town, State: CUMBERLAND, MD

21. Signature of Funeral Service Licensee: Douglas S Hafer
22. Name and Address of Facility: HAFER CHAPEL OF THE HILLS MORTUARY 12302 NATIONAL HWY, LAVALE, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC MELANOMA — FIFTEEN YEARS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: DJJ417 (MD)
29d. Date signed (Month, Day, Year): NOVEMBER 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J.R. MOEN, M.D 12068 NATIONAL HIGHWAY LAVALE, MARYLAND 21502

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001
32. Registrar's Signature: Barbara B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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mls

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM#5 PR. F.H. G802 12-28-01 JAB *Certificate of Death* Reg. No. 2001 38531

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SEYMOUR A. MARTIN
2. Date of Death Month Dey Year: NOVEMBER 13, 2001
3. Time of Death: 20:30
4a. Facility Name *(If not institution, give street and number)*: MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 217-10-0385 ~~317-10-0385~~
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: July 18,1919
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: WV
10b. County: Mineral
10c. City, Town or Location: Burlington
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: HC 84, Box 100
10f. Zip Code: 26710
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Detes: WW II
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Foreman
16b. Kind of Business/Industry: Venetian Blind Manufacturing

17. Fether's Neme *(First, Middle, Last)*: Boyd F. Martin
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Lucy B. Myers

19a. Informent's Neme/Reletionship *(Type, Print)*: Viola L. Martin/ Wife
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: HC 84, Box 100 Burlington, WV 26710

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Burlington Cemetery
Dete: Nov. 17 2001
20c. Location - City or Town, Stete: Burlington, WV

21. Signeture of Funerel Service Licensee: Brian L Smith
22. Name end Address of Fecility: Smith Funeral Home Rt. 2, Box 1-A Burlington, WV 26710

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart feilure. List only one ceuse on eech line. Approximate Intervel Between Onset and Deeth

Immediete Cause (Finel diseese or condition resulting in deeth)
a. PNEUMONIA AND ACUTE RESPIRATORY DISTRESS SYNDROME WITH RESPIRATORY FAILURE — 1 MONTH

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings availeble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Deeth *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Menner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end place, end due to tha cause(s) end menner steted.

29b. Signature and title of certifier: Mark
29c. License number: D35481
29d. Dete signed *(Month, Dey, Year)*: NOVEMBER 15 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAGIN, MARK A., M.D., 600 MEMORIAL AVENUE, SUITE 400, CUMBERLAND, MD 21502

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 2 1 2001
32. Registrer's Signeture: Pamela D Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

SEYMOUR MARTIN 217-10-0385

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

6

MD

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38532

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCES T. MERSON
2. Date of Death (Month, Day, Year): November 16, 2001
3. Time of Death: 12:10 pm
4a. Facility Name (If not institution, give street and number): Northampton Manor
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick County

Funeral Director

5. Social Security Number: 216-22-2377
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 11, 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll County
10c. City, Town or Location: Taneytown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 308 Taney Drive
10f. Zip Code: 21787
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): secretary / bookkeeper
16b. Kind of Business/Industry: administration

17. Father's Name (First, Middle, Last): Oliver Baker Leaman
18. Mother's Name (First, Middle, Maiden Surname): Mary Katherine Quilter

19a. Informant's Name/Relationship (Type, Print): Patricia M. Sussman / daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10601 Tanager Lane Potomac, Maryland 20854

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematorium
Date: Nov. 17 2001
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Alan C. Purvis M01072
22. Name and Address of Facility: Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Advanced End-Stage Dementia	4-5yrs.
Due to (or as a consequence of): b.	C.O.P.D.	5yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Osteoporosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D21944
29d. Date signed (Month, Day, Year): 11/16/9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jon J Grisson MD 300 W. 9th St. Frederick, Md 21701

State Registrar

31. Date filed (Month, Day, Year): NOV 19 2001
32. Registrar's Signature

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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CEW 2

DHMH 16 Rev 6/95

Robert W. Madden
CJ
01-6662-013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 121201:ITEMS#23a,27,28a-f per ME C302 ss

Certificate of Death

Reg. No. 2001 38533

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Robert W. Madden	November 23 2001	12:57 P.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Carroll County General Hospital	Westminster	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
019-20-7296	1☒M 2☐F	74 Yrs.			Mar 14,1927	Massachusetts

To Be Completed by Funeral Director

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Carroll	Hampstead	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whel Country?
2810 Hoffman Mill Road	21074	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐Never Merried 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Detes: 1945-1946	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementery/Secondary (0-12)	Cottege (1-4or 5+)		
	5+	Physicist	National Security

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
William F. Madden	Julia Jurre

19e. Informant's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
Davida Madden, wife	2810 Hoffman Mill Rd, Hampstead, MD 21074

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other place)	Dete	20c. Location - City or Town, State
1☐Buriel 2☒Cremation 3☐Removel from State 4☐Donation 5☐Other (Specify)	Carroll Cremations	11/27/2001	Hampstead, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Steven W Eline MD723	Eline Funeral Home 934 South Main St, Hampstead, MD 21074

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23e. Pert1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. Lisl only one cause on each line.

Approximete Interval Belween Onset and Death

Immediate Cause (Finel diseese or condition resulting in death): a. HEMOPERITONEUM COMPLICATING LIVER CIRRHOSIS FOLLOWING PARACENTESIS

Due to (or as e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thel initieted events resulting in death) Lasl

b. Due lo (or es e consequence of):

c. Due lo (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnent in the pest 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel deelh 3☐Ectopic pregnency 4☐Pregnent at time of deeth 5☐Other (specify) 9☐Unknown

23d. Data ot delivery Month Day Year

Pert If. **Other significant conditions** contributing to deelh bul nol resulting in the underlying ceuse given in Pert I.

23e. Did tobecco use contribule lo the cause of deeth? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24e. Was an eulopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior lo completion of ceuse of death? 1☒Yes 2☐No

25. Wes case referred to medical exeminer? 1☒Yes 2☐No

28. Place of Deeth (Check only one)
Hospitel: 1☒Inpatienl 2☐ER/Oulpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury el Work?	28d. Describe how injury occurred
1☐Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☒Could not be determined	11-19-01	Unknown M	1☐Yes 2☒No	hemorrhage following paracentesis procedure

28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify): hospital

28f. Location (Street and Number or Rural Route Number, City or Town, Stete): St. Joseph's Hospital, Towson, MD

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to lhe cause(s) end menner as sleted.
2☒ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) end manner slaled.

29b. Signature end litle of certifier	29c. License number	29d. Dete signed (Month, Dey, Year)
▶ J M. Titus	O.C.M.E.	November 24, 2001

30. Name end address of perso who completed cause of deeth (Item 23a) (Type, Print)
JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
NOV 27 2001	▶ Geneva D Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 le marked other than "neturel', or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

WSL
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38534

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Browning Main

2. Date of Death: Month November Day 13 Year 2001

3. Time of Death: 3:00 PM

4a. Facility Name (If not institution, give street and number): Citizen Nursing Home

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 216-46-5469

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 04/12/1912

9. Birthplace (State or Foreign Country): Tennessee

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Havre de Grace

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1231 Ontario St. Ext.

10f. Zip Code: 21078

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

18b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Charles Browning

18. Mother's Name (First, Middle, Maiden Surname): Olivia Munsey

19a. Informant's Name/Relationship (Type, Print): Joyce Adams- Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2317 Shuresville Rd., Darlington, MD 21034

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Darlington Cem.

Date: 11/15/2001

20c. Location - City or Town, State: Darlington, MD

21. Signature of Funeral Service Licensee: Sylvaine M. Smith

22. Name and Address of Facility: Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Gastrointestinal bleed — 1 Month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration

Anemia

Bipolar Disorder

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mirza A-Baig MD

29c. License number: D43115

29d. Date signed (Month, Day, Year): 11-14-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 615 S. Union Ave, HDG, MD 21078

State Registrar

31. Date filed (Month, Day, Year): NOV 19 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Main, Ruth

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38535

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Herbert A. Nickel

2. Date of Death Month: Nov Day: 25 Year: 2001

3. Time of Death: 03:00 AM

4a. Facility Name (If not institution, give street and number): 7196 Washington Boulevard

4b. City, Town, or Location of Death: Elkridge

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 212-32-8818

8. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 2, 1919

9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Elkridge

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7196 Washington Boulevard

10f. Zip Code: 21075

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist

18b. Kind of Business/Industry: Carr-Lowry Glass Co.

17. Father's Name (First, Middle, Last): Albert Nickel

18. Mother's Name (First, Middle, Maiden Surname): Hedwig Metan

19a. Informant's Name/Relationship (Type, Print): Emma Nickel/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7196 Washington Blvd. Elkridge, Maryland 21075

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): All County Crematory

Date: 11/25/2001

20c. Location - City or Town, State: Sykesville, Maryland

21. Signature of Funeral Service Licensee: [signature] M01142

22. Name and Address of Facility: Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease — 4 years

Due to (or as a consequence of):

b. Congestive Heart Failure — 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse givan in Part I.

23e. Did tobacco use contribute to tha cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Othar (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurrad at tha time, date and place, and due to the cause(s) and manner es steted. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to tha ceuse(s) and manner stated.

29b. Signature and title of certifier: [signature] MD Deputy ME

29c. License number: D31473

29d. Date signed (Month, Day, Year): Nov 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PATRYCE A. TOYE, MD 4565 Hemlock Cone Way Ellicott City MD 21042

State Registrar

31. Date filed (Month, Day, Year): NOV 26 2001

32. Registrar's Signature: [signature]

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(10)

CJ

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38536

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marie Frances Probst
2. Date of Death (Month, Day, Year): November 16, 2001
3. Time of Death: 1:20 pm
4a. Facility Name (If not institution, give street and number): 4400 Forge Road
4b. City, Town, or Location of Death: Perry Hall
4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 212-20-3944
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 7, 1926
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4400 Forge Road
10f. Zip Code: 21128
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William Cochran
18. Mother's Name (First, Middle, Maiden Surname): Grace Riley

19a. Informant's Name/Relationship (Type, Print): (son) Mr. Charles R. Probst, Jr.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1132 Elbank Avenue, Baltimore, MD 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: 11/19/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Brian A. Wellner
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Road Baltimore, Maryland 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. lung cancer — 4 weeks
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: emphysema. cerebrovascular accident

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Bruce Rosenberg
29c. License number: D24121
29d. Date signed (Month, Day, Year): 11/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRUCE ROSENBERG 218 CHURCH LA. BALTO, MD 21208

State Registrar

31. Date filed (Month, Day, Year): NOV 19 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

jm

24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38537

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANK PANUSKA, Jr.

2. Date of Death (Month, Day, Year): NOVEMBER 11, 2001

3. Time of Death: 2022 M

4a. Facility Name (If not institution, give street and number): Upper Chesapeake Medical Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 268-20-3147

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 8/31/1926

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Whiteford

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1522 Deep Run Road

10f. Zip Code: 21160

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician

18b. Kind of Business/Industry: Electrical/Building

17. Father's Name (First, Middle, Last): Frank Panuska, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Suzanne M. Pugh - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 Middle Ave., Apt. 1, Livermore Falls, Maine

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Mem. Gdns

Date: 11/15/01

20c. Location - City or Town, State: Bel Air, MD

21. Signature of Funeral Service Licensee: Jeffrey L. Lordi

22. Name and Address of Facility: Harkins Funeral Home, Inc., Delta, PA

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PSEUDOMONAS SEPTICEMIA — 5 days

Due to (or as a consequence of):

b. PERFERATED VISCOUS — 5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnent at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SEVERE CORONARY ARTERY DISEASE RENAL FAILURE, HYPERNATREMIA, SHOCK

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier:

29c. License number: D16444

29d. Date signed (Month, Day, Year): NOVEMBER 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VIJAY S. NAIR M.D. 2112 BELAIR ROAD FALLSTON, MD. 21047

State Registrar

31. Date filed (Month, Day, Year): NOV 15 2001

32. Registrar's Signature: Donna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CAJ

FRANK PANUSKA, JR

14+1

Amended #03, 30; mk, 11/21/01, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38538

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
MARGARET HELENA RICE	November 16, 2001	23:44PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SACRED HEART HOSPITAL	CUMBERLAND	ALLEGANY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-76-2328	1☐M 2☒F	90 Yrs.			JULY 26, 1911	PENNSYLVANIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	ALLEGANY	FLINTSTONE	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11810 CRESAP MILL ROAD, S.E.	21530	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOMEMAKER	HOME

17. Father's Name (First, Middle, Last)	16. Mother's Name (First, Middle, Maiden Surname)
DANIEL BENDER	ALPHA CRABTREE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RONALD RICE / SON	11814 CRESAP MILL ROAD, SE, FLINTSTONE, MD 21530

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MT. PLEASANT CEMETERY	11/19/2001	CUMBERLAND, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Doug A. Upchurch	UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute respiratory failure	40"
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Pneumonitis	48 h
	c. Due to (or as a consequence of): C.H.F.	5 years
	d. Due to (or as a consequence of): Massive CVA	3 m.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

NTP –

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☑ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and dua to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D08377	November 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
~~Gabriel Legnadi, M.D.~~ Jose T. Loveria Jr 902 Seton Drive Cumberland MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 21 2001	[signature] G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Rice, Margaret Helena DOB: 07/26/11 212-76-2328

4/2 NAS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38539

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Christina Delores Ryan	November 16, 2001	10:10p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Laurel Regional Hospital	Laurel	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-56-9695	1 ☐ M 2 ☒ F XX	63 Yrs.			Apr. 8, 1938	Panama

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	Laurel	XX ☒ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
807 Karen Court Apt. 101	20707	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: XX	1 ☒ Yes 2 ☐ No Specify: Panamanian XX	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
	2 years	Registered Nurse	Health Care

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Felix Plumber	Sylvina Jacobs

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Clifford D. Ryan / son	2915 Barton Avenue Richmond, VA 23222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metropolitan Crem.	Nov. 24, 01	Alexandria, Virgina

21. Signature of Funeral Service Licensee ▶ /M00770

22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, MAryland 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolism

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Deep Vein Thrombosis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Data of delivery Month Day Year
1 ☐ Yes 2 ☒ No XX 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnency 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Systemic Lupus Erythematosus

S/P Bilateral Knee Replacement

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 ☐ Yes 2 ☒ No	Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Villamor S. Reyes M.D.	D29671	11-16-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Villamor S. Reyes, M.D. 6501 Landover Road Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 21 2001	▶ Bruce G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(5)

CJ

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38540

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frank T. Reiter, Jr.

2. Date of Death (Month, Day, Year): November 23, 2001

3. Time of Death: 6:20 P M

4a. Facility Name (If not institution, give street and number): 10142 Maplewood Drive

4b. City, Town, or Location of Death: Ellicott City

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 213 10 4260

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 25, 1914

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: MD

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 10142 Maplewood Drive

10f. Zip Code: 21042

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Entrepreneur/Accountant

16b. Kind of Business/Industry: Maryland Race Track

17. Father's Name (First, Middle, Last): Frank T. Reiter, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Marie E. Kessler

19a. Informant's Name/Relationship (Type, Print): Joanne R. Groom/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 606 Muirfield Circle Dagsboro, DE 19939

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Crest Lawn Mem. Gard.

Date: 11-27-2001

20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funeral Service Licensee: Sharon Collins - M01044 Witzke

22. Name and Address of Facility: Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)

a. Sepsis — Due to (or as e consequence of): — Days

Sequentially list conditions, it any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

b. Pressure Sore — Due to (or as e consequence of): — Weeks

c. Debility — Due to (or as a consequence of): — Years

d. —

IF FEMALE:

23b. Was decedent pregnant in the pest 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Dete of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the ceuse of deeth? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) asst. livg

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Yeer):

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):

28f. Location (Street end Number or Rural Route Number, City or Town, Stete):

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as steted. 2 [ ] Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and menner stated.

29b. Signature and title of certifier:

29c. License number: D36786 ME

29d. Date signed (Month, Day, Yeer): Nov. 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeff Katzmer 1061 Deepage Dr, #104, Columbia MD 21045

State Registrar

31. Date filed (Month, Day, Year): NOV 27 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38541

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ZELLENE MAE SINGLETON

2. Date of Death (Month, Day, Year): NOVEMBER 14, 2001

3. Time of Death: 4:58 PM

4a. Facility Name (If not institution, give street and number): MERCY HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-38-2461

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT 13 1941

9. Birthplace (State or Foreign Country): W.VA.

Usual Residence of Decedent

10a. State: MARYLAND | 10b. County: ALLEGANY | 10c. City, Town or Location: CUMBERLAND | 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 235 PACA STREET QUEEN CITY TOWERS | 10f. Zip Code: 21502 | 10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOME MAKER

16b. Kind of Business/Industry: HOME MAKER

17. Father's Name (First, Middle, Last): EDGAR JAMES GOLDEN

18. Mother's Name (First, Middle, Maiden Surname): JULIA ELIZABETH HENDERSON

19a. Informant's Name/Relationship (Type, Print): RAYMOND SINGLETON SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 342 COLUMBIA STREET CUMBERLAND MARYLAND 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ABE CEMETERY | Date: NOVEMBER 17 2001

20c. Location - City or Town, State: RFD RIDGELEY W.VA.

21. Signature of Funeral Service Licensee: Dale L. Merritt

22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Metastatic Breast Cancer.

Due to (or as a consequence of):
b. Congestive Heart Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) STELLA MARIS AT MERCY Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D 40854

29d. Date signed (Month, Day, Year): NOVEMBER 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG, 301 St Paul Pl, BALTIMORE MD 21202

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38542

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Elizabeth Allen Stewart
2. Data of Death Month Day Year: November 27, 2001
3. Time of Death: 6:45 p M
4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 214-30-0336
6. Sex: 1☐M 2☒F XX
7. Age (In yrs. last birthday): 68 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
6. Date of Birth (Month, Day, Year): April 2, 1933
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Laurel
10d. Insida City Limits: 1☐Yas 2☒No XX
10e. Street and Number: 251 Marganza South
10f. Zip Coda: 20724
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed X 4☐Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐Yas 2☒No If Yes, Giva Year or Dates:
13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐Yes 2☒No Specify:
14. Race - Amarican Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): Grade 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Secretary
18b. Kind of Businass/Industry: Government

17. Fathar's Name (First, Middle, Last): Alvin E. Allen
18. Mother's Nama (First, Middla, Maiden Surnama): Grace Godding

19a. Informant's Name/Relationship (Type, Print): Allen P. Stewart / son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8040 Savage-Guildford Road Jessup, MD 20794

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from Stata 4☐Donation 5☐Other (Specify)
20b. Placa of Disposition (Name of cematary, cramatory or othar placa): Md Nat. Mem. Park
Dete: Dec 3, 2001
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: [signature] / M00770
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only ona causa on aach lina.

Approximate Intarvat Between Onsat and Daath

Immediata Cause (Final disease or condition resulting in death):
a. Metastatic Colon Cancer — 1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
b.
Dua to (or as a consequanca of):
c.
Dua to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No XX 9☐Unknown
23c. If yas, outcome of pregnancy 1☐Liva birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of deeth 5☐Othar (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.
cardiac arrest with anoxic encephalepathy
9 days prior to death
Diabetes with complications

23a. Did tobacco usa contributa to tha causa of daath? 1☐Yas 2☐No XX 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yas 2☒No
24b. Were autopsy findings availabla prior to compiation of causa of daath? 1☐Yas 2☒No XX

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Placa of Daath (Check only ona) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Othar: 4☐Nursing Home 5☐Rasidanca 6☐Othar (Specify)
27. Manner of Death X 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be datarmined
28a. Dete of Injury (Month, Day Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1☐Yas 2☐No
28d. Dascribe how injury occurred
28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify)
28f. Location (Straat and Numbar or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledga, daath occurred at the tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and mannar stated.
29b. Signature and title of certifier: [signature]
29c. Licensa number: D34018
29d. Data signed (Month, Day, Year): November 28, 2001
30. Name and address of person who completed causa of death (Item 23a) (Type, Print): 14201 Laurel Park Drive Suite 214 Laurel, Maryland 20707

State Registrar

31. Data filed (Month, Day, Year): NOV 3 0 2001
32. Registrar's Signatura: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked othar than "natural", or itams 23a or 28a-f show any injury or other traumatic avant, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25

cgf

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38543

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Teresia (NMN) Urich

2. Date of Death (Month, Day, Year): November 11, 2001

3. Time of Death: 6:35 P.M.

4a. Facility Name (If not institution, give street and number): 2120 Pleasantville Road

4b. City, Town, or Location of Death: Fallston,

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 220-76-3364

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 7, 1913

9. Birthplace (State or Foreign Country): Romania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Harford | 10c. City, Town or Location: Fallston | 10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2120 Pleasantville Road | 10f. Zip Code: 21047 | 10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Johann (NMN) Schlauch

18. Mother's Name (First, Middle, Maiden Surname): Magdalena (NMN) Hein

19a. Informant's Name/Relationship (Type, Print): Renatte J. English /Daughter Grand

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 118 Locust Dr., Catonsville, MD 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Darlington Cemetery

Date: 11-14-01

20c. Location - City or Town, State: Darlington, Maryland

21. Signature of General Service Licensee: [signature]

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Congestive Heart Failure	Two Months
Due to (or as a consequence of): b.	Ischemic Heart Disease	Five Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☑ No | 28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ken K Snyder MD

29c. License number: D33642

29d. Date signed (Month, Day, Year): November 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kevin C Snyder MD 754 Hickory Avenue Bel Air MD 21014

State Registrar

31. Date filed (Month, Day, Year): NOV 14 2001

32. Registrar's Signature: [signature] D Sparks

4

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38544

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Edna O. Vallee	November 28 2001	9:25 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
9444 White Spring Way	Columbia	Howard

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
324-05-1774	1☐M 2☒F	91 Yrs.			Nov. 23, 1910	Illinois

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Howard	Columbia	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6336 Cedar Lane Apartment 175	21044	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yeer or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Emil Ogren	Anna Forslund

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Nan Nessel/Daughter	9444 White Spring Way Columbia, Maryland 21046

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metro Crematory	11/29/2001	Catonsville, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Harry H. Witzke's Family FH, Inc. M01142 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebral Vascular Accident	4 wks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. General Atherosclerosis	yrs
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at tima of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Hypothyroidism

23e. Did tobacco use contribute to tha causa of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Daughters Home

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es steted. 2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the ceuse(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
Melvin Joel Kordon MD	D06588	Nov. 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Melvin J Kordon MD 9801 Dorsey Hall Drive Ellicott City Md 21042

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 30 2001	Donna G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(19)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38545

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Henry Wilgus

2. Date of Death: Month NOVEMBER Day 26, Year 2001

3. Time of Death: 11:45 PM

4a. Facility Name (If not institution, give street and number): ST. AGNES HOSPITAL, 900 CATON AVENUE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 165-01-1167

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 26, 1917

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3320 Benson Avenue

10f. Zip Code: 21227

10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Field Engineer

16b. Kind of Business/Industry: Sperry Jiroscope

17. Father's Name (First, Middle, Last): Henry A. Wilgus

18. Mother's Name (First, Middle, Maiden Surname): May Von Bramer

19a. Informant's Name/Relationship (Type, Print): Ellen Bell/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3773 Dorsey Search Circle Ellicott City, MD 21043

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory | Date: 11/27/01

20c. Location - City or Town, State: Catonsville, Maryland

21. Signature of Funeral Service Licensee: Andre' Arnaud M00845

22. Name and Address of Facility: Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. cardiac arrest

Due to (or as a consequence of):
b. coronary artery disease

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Hypertension

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Disease

Pulmonary Embolism

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: TUN MYINT, M.D.

29c. License number: 15626

29d. Date signed (Month, Day, Year): November 26, 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TUN MYINT, 900 CATON AVENUE, BALTIMORE, MD 21229.

State Registrar

31. Date filed (Month, Day, Year): NOV 27 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

NAME William Wilgus

(12) ded

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38546

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Benny Joe Williams

2. Date of Death Month Day Year: November 9, 2001

3. Time of Death: 8:45 A M

4a. Facility Name (If not institution, give street and number): 506 Sequoia Drive

4b. City, Town, or Location of Death: Edgewood

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 216-36-7276

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 15, 1939

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Edgewood

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 506 Sequoia Drive

10f. Zip Code: 21040

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10th Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Scheduling Clerk

16b. Kind of Business/Industry: Steel Industry

17. Father's Name (First, Middle, Last): Romie F. Williams

18. Mother's Name (First, Middle, Meiden Sumeme): Sarah Perdue

19a. Informant's Name/Relationship (Type, Print): Eleanor Williams (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 506 Sequoia Drive, Edgewood, Maryland 21040

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Bayview Crematory

Date: 11/13/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Carol Blumberg

22. Name and Address of Facility: Schimunek Funeral Home of Bel Air Inc, 610 W. Macphail Road, Bel Air, Md. 21014

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cerdiec or raspiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Epitheliod Angiosarcoma — 6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete and place, end dua to the cause(s) end manner as steted. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to tha causa(s) and manner stated.

29b. Signature and title of certifier: ▶ Lance Lassiter

29c. License number: D0056099

29d. Date signed (Month, Day, Yaer): NOVEMBER 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LANCE LASSITER, 401 N. BROADWAY, BALTIMORE MD 21231

State Registrar

31. Date filed (Month, Day, Year): NOV 14 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM#10g per fh G802 120701 ss AMENDED 120401:ITEM#9 per fh G802 ss

Certificate of Death

Reg. # 2001 38547

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Rasheed	Fola	Adeshina	December	2	2001	5:05 aM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Union Memorial Hospital	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-78-5767	1☒M 2☐F	53 Yrs.					12 19 47	Nigeria ~~Niagara~~

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Parkville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9 Debonair Ct.	21234	~~U.S.A.~~ Nigeria

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes ☒No If Yes, Give Year or Dates:	1☐Yes ☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12th grade	4 yrs	Correction Officer	Baltimore City Detention

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Kosoko Adeshine	Jemihat

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Karen Adeshina-Wife	9 Debonair Ct., Parkville Md 21234

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒1 Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	King Memorial Park	12/3/01	Randallstown, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Lynette K. Jones	March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration pneumonia	12 hrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Sickle Cell Anemia	53 yrs
	Due to (or as a consequence of): c. Hyperkalemia	6 hrs
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure
Chronic Renal Insufficiency
Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Stephen Nguyen	AT 2438946-311	December 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEPHEN NGUYEN, 301 East University Parkway, Baltimore, Maryland 21218

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	▶ Bernice D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

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5

DHMH 17 Rev 1/2001

ORIGINAL

CPM
01-6754-510
MARK ABERNATHY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 121801:ITEMS#23a,27,28a-f per ME G802 ss

Certificate of Death

Reg. No. 2001 38548

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mark S. Abernathy

2. Data of Death (Month, Day, Year): NOVEMBER 28, 2001

3. Time of Death: 15:51

4a. Facility Name (If not institution, give street and number): 802 SOUTH CAROLINE STREET

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-98-9341

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 32 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 22, 1969

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 802 S. Caroline Street

10f. Zip Coda: 21231

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Brewer

16b. Kind of Business/Industry: Old Dominion Brewing Company

17. Father's Name (First, Middle, Last): James Abernathy

18. Mother's Name (First, Middle, Maiden Surname): Juanita

19a. Informant's Name/Relationship (Type, Print): James Abernathy Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3847 Quarry Avenue Baltimore, Maryland 21211

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery

Date: 12/3/01

20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Service Licensee: Lynn B. Henss

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 21211
3631 Falls Road, Baltimore, Maryland

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ALCOHOL INTOXICATION COMPICATED BY DROWNING

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death: 1☐ Neturel 2☒ Accident 3☐ Suicida 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): Found: 11-28-01

28b. Time of Injury: Found: 3:45p M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Subject ingested alcohol and drowning

28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify): Pier near Baltimore Harbor

28f. Location (Street and Number or Rural Route Number, City or Town, State): 802 S. Caroline St., Baltimore, MD

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. Kinga

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): NOVEMBER 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: Theresa G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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I pmdg OK

01-6763-510
B.K.S
CYNTHIA BRYANT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38549

UNPENDED 012502: ITEMS#23a, 27 per ME G803 ss

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): Cynthia M. Bryant
2. Date of Death Month Day Year: NOV. 29, 2001
3. Time of Death: 1014 AM
4a. Facility Name (If not institution, give street and number): 2503 VIOLET AVENUE #4105
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A
5. Social Security Number: 217-66-6715
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 44 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 23, 1957
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2503 Violet Ave #4105
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nursing Assistant
16b. Kind of Business/Industry: Nursing

17. Father's Neme (First, Middle, Last): Theodore Bryant
18. Mother's Neme (First, Middle, Maiden Surname): Imerdean Baisdan

19a. Informant's Name/Relationship (Type, Print): Dontae Winslow/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 820 Park Ave #3 Balto, MD 21201

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Vo Hells Memorial Garden
Date: DEC 4, 01
20c. Location - City or Town, State: Baltimore, MD

21. Signeture of Funeral Service Licensee: Ronald Grayson
22. Name and Address of Facility: Ronald A Grayson Funeral Service 8312 Liberty Rd. Balt. MD 21244

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACQUIRED IMMUNE DEFICIENCY SYNDROME
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last
b.
Due to (or es e consequenca of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? ☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☒ Other (Specify) AT SCENE
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and placa, and due to tha cause(s) and menner as stated. ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to tha cause(s) and menner stated.

29b. Signature and title of cartifier: Maryrite DeCree MD
29c. License number: O.C.M.E
29d. Date signed (Month, Dey, Year): NOV. 30, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): MARGRITE A. KOREN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38550

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna Baulne
2. Date of Death: Month 11 Day 29 Year 2001
3. Time of Death: 2:15pm M
4a. Facility Name (If not institution, give street and number): Millennium Nursing & Rehab
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 009-09-2542
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jun 26, 1917
9. Birthplace (State or Foreign Country): MA

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Severna Park
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 466 Lission Street
10f. Zip Code: 21146
10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Riveter
16b. Kind of Business/Industry: Sikorsky Aircraft

17. Father's Name (First, Middle, Last): John Luszcz
18. Mother's Name (First, Middle, Maiden Surname): Mary Jacobus

19a. Informant's Name/Relationship (Type, Print): Mrs. Janice B. Amenta/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 466 Lission Street, Severna Park, MD 21146

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: Dec 1 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Gale D Lohmann
22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular Accident — 7 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Hypertensive Arteriosclerotic Cardiovascular Disease — 15 years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

If FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Harjit Singh MD
29c. License number: D0014160
29d. Date signed (Month, Day, Year): 11/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: Benjamin G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Anna Baulne
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 38551

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DWAYNE BASL
2. Date of Death (Month, Day, Year): DECEMBER 1 2001
3. Time of Death: 1438
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 542-60-9932
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 51 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jun 18, 1950
9. Birthplace (State or Foreign Country): OR

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Edgewood
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 1402 Clearview Rd
10f. Zip Code: 21040
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Journeyman Lineman
16b. Kind of Business/Industry: Electric

17. Father's Name (First, Middle, Last): Donald Basl
18. Mother's Name (First, Middle, Maiden Surname): Frances Johnson

19a. Informant's Name/Relationship (Type, Print): Sherrie Lee Basl/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1402 Clearview Rd, Edgewood, MD 21040

20a. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: Dec 4 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Stephen D Lohmann
22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. INTRACRANIAL HEMORRHAGE — 26 DAYS
Due to (or as a consequence of):
b. BACTERIAL ENDOCARDITIS — 28 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier: Carlos A. Bagley MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): DECEMBER 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Carlos A. Bagley 600 North Wolfe St. Baltimore MD 21287

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38552

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSE MARY BELLI
2. Date of Death (Month, Day, Year): NOVEMBER 29, 2001
3. Time of Death: 7:18 AM
4a. Facility Name (If not institution, give street and number): SAINT JOSEPH MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-14-4850
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8/15/1924
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: TOWSON
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8136 PLEASANT PLAINS ROAD
10f. Zip Code: 21286
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BOOKKEEPER
16b. Kind of Business/Industry: CATHOLIC CHARITIES

17. Father's Name (First, Middle, Last): ALBERT BELLI
18. Mother's Name (First, Middle, Maiden Surname): VICTORIA COLANDRIA

19a. Informant's Name/Relationship (Type, Print): ANNA E. FINK SISTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1666 THETFORD ROAD BALTIMORE, MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MOST HOLY REDEEMER CEM.
Date: 12/7/01
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Heather N. Hayes
22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	SEPSIS	2 WEEKS
Due to (or as a consequence of):		
b.	ACUTE CEREBROVASCULAR ACCIDENT	16 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	ACUTE RENAL FAILURE	4 DAYS
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: POSSIBLE ASPIRATION PNEUMONIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier: Fahed Kouli MD
29c. License number: D 48271
29d. Date signed (Month, Day, Year): 11-29-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FAHED KOULI, MD , 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: Regina D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RF

RA 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38553

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Sachiko Barone	DEC 2, 2001	8:30p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
113 Margate Road	Lutherville	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
122-32-5824	1☐M 2☒F	68 Yrs.					NOV 18, 1933	Japan

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Lutherville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
113 Margate Road	21093	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Japanese

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Waitress	Restaurant

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
UNK. Shoji	Kiyoko UNK.

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lisa Ann Smith/Daughter	27 Arwell Court Baltimore, MD 21236

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metro Crematory Inc.	12-3-01	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Dawn F. McDonald	Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. metastatic neuroendocrine cell lung cancer — 8 mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Richard L. Hlusky MD	D36814	12/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard L. Hlusky MD 1600 Dulaney Dr, Suite 3-2 Towson MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	▶ Bonnie D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38554

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLOTTE NAOMI BRENT
2. Date of Death (Month, Day, Year): DECEMBER 1, 2001
3. Time of Death: 10:15pm

4a. Facility Name (If not institution, give street and number): 3855 GREENSPRING AVE. APT 318
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-10-6804
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-24-1909
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3855 GREENSPRING AVE. APT 318
10f. Zip Code: 21211
10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): -12- | College (1-4or 5+): -3-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ADMINISTRATIVE ASSISTANT
16b. Kind of Business/Industry: GOVERNMENT

17. Father's Name (First, Middle, Last): HOWARD D. BRENT SR.
18. Mother's Name (First, Middle, Maiden Surname): LAVINIA CLASH

19a. Informant's Name/Relationship (Type, Print): WILLIAM A. BRENT(BROTHER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15 S. ABINGTON AVE. BALTIMORE, MARYLAND 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): MT. CALVARY CEMETERY | Date: 12-7-2001
20c. Location - City or Town, State: GLEN BURNIE, MARYLAND

21. Signature of Funeral Service Licensee: Jonathan D. Hibner
22. Name and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart tailure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PULMONARY EMBOLUS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was cese referred to medicel examinar? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ Medicel Examiner: On the basis of exemination and/or investigetion, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Maurice Queens
29c. License number: D38190
29d. Date signed (Month, Day, Year): 12/03/2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): MAURICE QUEENS MD 2225 W. NORTH Ave BALTO MD 21216

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: Jennie D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

16

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38555

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RUTH BLOCK
2. Data of Death Month Dey Year: NOVEMBER 29,2001
3. Time of Death: 11:30 AM
4a Facility Name *(If not institution, give street and number)*: 8204 SPRING BOTTOM WAY
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 294-14-7365
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: JAN.23,1924
9. Birthplace *(State or Foreign Country)*: MO

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8204 SPRING BOTTOM WAY
10f. Zip Code: 21208
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yas 2☐ No If Yes, Give Yeer or Dates:
13. Wes Decadent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puarto Rican, etc.): 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) / College (1-4or 5+): 4
16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: NURSE
16b. Kind of Business/Industry: MEDICAL

17. Father's Name *(First, Middle, Last)*: RICHARD WADDELL
18. Mother's Neme *(First, Middle, Maiden Surneme)*: MARY (UNKNOWN)

19e. Informent's Neme/Reletionship *(Type, Print)*: RICHARD BLOCK / SON
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: P.O. BOX 528 - RANCHO SANTA FE, CA 92067

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Placa of Disposition *(Name of cemetery, cremetory or other place)*: ARLINGTON CHIZUK AMUNO
Dete: 12/2/01
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funarel Service Licensee: Scott M. Cutler
22. Name end Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart feilura. List only one causa on eech line.

Approximete Intervel Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in deeth)
e. Metastatic Lung Cancer — 18 months
Due to (or es a consequence of):
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Lest
b.
Due to (or es e consequence of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other stgnificant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place ot Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exemination and/or investigetion, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: M.D.
29c. Licansa number: D 45390
29d. Dete signed *(Month, Dey, Year)*: NOVEMBER 29th, 2001

30. Nema and addrass ot person who completed cause of death (Item 23e) (Type, Print): MYO MD(MD) 8114 SANDPIPER CIRCLE #211, BALTIMORE, MD 21236

State Registrar

31. Dete filed *(Month, Dey, Year)*: DEC 04 2001
32. Registrer's Signeture: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38556

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVELYN CLASH

2. Date of Death: Month Nov Day 29 Year 2001

3. Time of Death: 2:20 PM

4a. Facility Name (If not Institution, give street and number): Genesis Homewood

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 214-16-5376

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 04 02 10

9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3000 Towanda Ave

10f. Zip Code: 21215

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 5th grade

College (1-4or 5+): na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher Aid

16b. Kind of Business/Industry: Baltimore City

17. Father's Name (First, Middle, Last): Clarence Davis

18. Mother's Name (First, Middle, Maiden Surname): Alleyne UNK

19a. Informant's Name/Relationship (Type, Print): John Clash-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2317 North Rosedale Street, Baltimore Md 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Auburn Cemetery

Date: 12/5/01

20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: John B. Johnson Jr.

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Acute Respiratory failure — 1 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Obstructive Lung Disease — years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D17118

29d. Date signed (Month, Day, Year): Nov 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Schwartz MD 7700 York Rd 21204

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: Donna D Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMND ITM# 10C PR. F.H. G802 11-4-01 JB

Certificate of Death

Reg. No. 2001 38557

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RANDOLPH R. CARTER
2. Date of Death Month: 11 Day: 30 Year: 01
3. Time of Death: 4:43 PM
4a. Facility Name (If not institution, give street and number): Sinai Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-34-9475
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 66 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06-27-1935
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: ~~2321 W.~~ BALTIMORE
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 2321 W. Mosher St
10f. Zip Code: 21216
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Auto Repair
16b. Kind of Business/Industry: General Motors

17. Father's Name (First, Middle, Last): Claybrook Carter
18. Mother's Name (First, Middle, Maiden Surname): Minnie Nutt

19a. Informant's Name/Relationship (Type, Print): Evelena Carter (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2321 W. Mosher St. Balto. MD. 21216

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Cemetery
Date: 12/7/2001
20c. Location - City or Town, State: Balto., MD.

21. Signature of Funeral Service Licensee: Vaughn C Greene
22. Name and Address of Facility: Vaughn C Greene Funeral Ser. 5151 Balto. Nat'l Pike Balto. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Cardiomyopathy
Due to (or as a consequence of):
b. Hypertensive Cardiovascular Disease
Due to (or as a consequence of):
c. Hypertension
Due to (or as a consequence of):
d. Chronic Renal Insufficiency

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Noel E. McCall, M.D.
29c. License number: D19607
29d. Date signed (Month, Day, Year): 12-03-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NOEL E. McCALL, M.D. 2411 W. BELVEDERE AVE. BALTIMORE, MD 21215

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR

RR ID

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38558

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Evelyn Clayton

2. Date of Death Month: 11 Day: 29 Year: 2001

3. Time of Death: 11:36pm

4a. Facility Name *(If not institution, give street and number)*: MD Masonic Homes 300 International Cr.

4b. City, Town, or Location of Death: Cockeysville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 084-24-9225

6. Sex: 1☐ M 2☒ F

7. Age *(in yrs. last birthday)*: 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 5, 1907

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Cockeysville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 300 International Circle

10f. Zip Code: 21030

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Self-employed

16b. Kind of Business/Industry: Medical

17. Father's Name *(First, Middle, Last)*: Marco Schwartz

18. Mother's Name *(First, Middle, Maiden Surname)*: Dora Goldberg

19a. Informant's Name/Relationship *(Type, Print)*: Valerie C. Aburn

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1009 Cowpens Road, Towson, Maryland 21286

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bayview Crematory

Date: Dec. 4, 2001

20c. Location - City or Town, State: Dundalk, Maryland

21. Signature of Funeral Service Licensee: Brian T. Chisholm

22. Name and Address of Facility: Brian T. Chisholm Funeral Services of Dulaney Valley, P.A. 200 E. Padonia Road, Timonium, Maryland 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Atherosclerotic Vascular Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Abnormal Chest X Ray (possible mass); Mild - moderate Dementia; history of pulmonary Embolism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R. Liberto, MD.

29c. License number: D21464

29d. Date signed *(Month, Day, Year)*: 12-4-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT LIBERTO, MD. 3502 Bank St Balto, Md 21224

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 2001

32. Registrar's Signature: [illegible] Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item10,10c e,f — State of Maryland / Department of Health and Mental Hygiene

Amend Item#17,18 perFHG802 12/10/01 EW G804 02/15/02 RR

Certificate of Death

Reg. No. 2001 38559

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARIAN ELIZABETH CONWAY

2. Date of Death (Month, Day, Year): DECEMBER 01, 01

3. Time of Death: 1:00 AM

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-40-6304

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 22, 1917

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: ~~Baltimore~~

10c. City, Town or Location: Baltimore ~~Silver Springs~~

10d. Inside City Limits: 1☐ Yes ~~2☐ No~~

10e. Street and Number: 2700 N.Charles ST. ~~13219 Conductor Way~~

10f. Zip Code: 21218 ~~20904~~

10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): 4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse

16b. Kind of Business/Industry: Bayview Hospital

17. Father's Name (First, Middle, Last): Burton Conway

18. Mother's Name (First, Middle, Maiden Surname): Carrie Whiting

19a. Informant's Name/Relationship (Type, Print): Karen D. Armstead - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13219 Conductor Way Silver Springs, Maryland 20904

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: 12/4/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Michael Zigler

22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, MD 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ASPIRATION PNEUMONIA	3 DAYS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	CEREBROVASCULAR ACCIDENT	3 MONTHS
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HTN, SEIZURE DISORDER,

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Dallumana MD

29c. License number: D47123

29d. Date signed (Month, Day, Year): DECEMBER 01, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH DUTHUMANA, 201 E UNIV. PKWY, BALTIMORE, MD 21218.

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the Burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

MARIAN CONWAY

RR

RR 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38560

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PHILIP T. COOMBS

2. Date of Death: Month December Day 1 Year 2001

3. Time of Death: 1905

4a. Facility Name (If not Institution, give street and number): St. Agnes Healthcare

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-20-0530

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 77 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 02, 1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10a. Street and Number: 149 North Denison Street

10f. Zip Code: 21229

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? [XX] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes [XX] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mail Handler

16b. Kind of Business/Industry: United States Postal Service

17. Father's Name (First, Middle, Last): John Morris Coombs

18. Mother's Name (First, Middle, Maiden Surname): Violet Cooper

19a. Informant's Name/Relationship (Type, Print): Mrs. Lenore M. Coombs- Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 149 North Denison Street Baltimore, Maryland 21229

20a. Method of Disposition: [XX] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison For. Vet. Cem.

Date: 12/07/01

20c. Location - City or Town, State: OwingsMills, Maryland

21. Signature of Funeral Service Licensee: ▶ Michael Zigler

22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, MD 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE MYOCARDIAL INFARCTION	1 hour
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ATHEROSCLEROTIC CORONARY DISEASE	10 years
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: PROSTATE CARCINOMA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: [X] 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): [X] 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jerome Snyder MD

29c. License number: D226YF

29d. Date signed (Month, Day, Year): December 01, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JEROME SNYDER, MD 900 SOUTH CLINTON AVENUE BALTIMORE MARYLAND 21229

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Coombs, Phillip

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38561

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GEORGE A. COLEMAN

2. Date of Death (Month, Day, Year): December 18 2001

3. Time of Death: 3:53 A M

4a. Facility Name *(If not institution, give street and number)*: NORTHWEST HOSPITAL

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 249-34-1278

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JAN. 28, 1926

9. Birthplace *(State or Foreign Country)*: SC

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: WOODLAWN

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7147 BEXHILL ROAD

10f. Zip Code: 21244

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* AFRICAN AMERICAN

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MACHINE OPERATOR

18b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name *(First, Middle, Last)*: PETE COLEMAN

18. Mother's Name *(First, Middle, Maiden Surname)*: JANE THOMPSON

19a. Informant's Name/Relationship *(Type, Print)*: JEANETTE V. COLEMAN (WIFE)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7147 BEXHILL ROAD BALTIMORE, MD 21244

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: KING MEMORIAL PK.

Date: 12/06/01

20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. VENTRICULAR TACHYCARDIA — Approximate Interval Between Onset and Death: MINUTES

Due to (or as a consequence of):

b. ACUTE MYOCARDIAL INFARCTION — DAYS

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE — YEARS

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fatal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other *(specify)* 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: SEPSIS, DIABETES MELLITUS, CEREBRO VASCULAR ACCIDENT, SACRAL DECUBITI, URINARY TRACT INFECTION, HYPERTENSION, CHRONIC OBSTRUCTIVE PULMO - NARY DISEASE

23a. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R Ranganayaki MD

29c. License number: D54288

29d. Data signed *(Month, Day, Year)*: December 21 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAMAMURTY T RANGANADAN, Northwest Hospital Medical Center

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 04 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM#11 per fh G802 120401 ss

Certificate of Death

Reg. No. 2001 38562

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Colkley

2. Date of Death: Month 11 | Day 29 | Year 01

3. Time of Death: 730 pm

4a. Facility Name (If not institution, give street and number): Mariner Health of North Arundel

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 261-09-0548

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12/8/13

9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: AnneArundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 281 Whitaker Rd

10f. Zip Code: 21122

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] ~~Married~~ 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): none | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foreman

16b. Kind of Business/Industry: Ship Yard

17. Father's Name (First, Middle, Last): Henry Carter

18. Mother's Name (First, Middle, Maiden Surname): Sarah Colkley

19a. Informant's Name/Relationship (Type, Print): Alvina Marie Walters/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 281 Whitaker Road Pasadena, MD 21122

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Metro Crematory, Inc. | Date: 11/30/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure — few hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD - Chr. Obstructive Pulm. Disease

Old CVAs, Hypertension

Depression, Bronchial Asthma

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rita Khandelwal Attending Physician

29c. License number: D029873

29d. Date signed (Month, Day, Year): 11/30/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RITA KHANDELWAL, M.D. 1600 S. CRAIN HWY, # 201 GLEN BURNIE, MD. 21061

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38563

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ronald Edward Cadle

2. Date of Death (Month, Day, Year): November 30, 2001

3. Time of Death: 4:45 A M

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-42-2502

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 57 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN 3, 1944

9. Birthplace (State or Foreign Country): West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 509 E. Joppa Road

10f. Zip Code: 21286

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Businass/Industry: Car Sales

17. Father's Name (First, Middle, Last): John H. Cadle

18. Mother's Name (First, Middle, Meiden Sumame): Violet Dickens

19a. Informant's Name/Relationship (Type, Print): Kelly Ann Cadle/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1808 Sunnyside Lane Baltimore, MD 21221

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Ptece of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.

Date: 12-3-01

20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

Medical Certification; To Be Completed by Phyalcian/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. End Stage Liver Disease

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b. Due to (or es a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. It yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetel deeth 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Othar (specify) 9 [ ] Unknown

23d. Date ot delivery Month Day Year

Part II. **Other significant conditions** contnbuting to deeth but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of deeth? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were eutopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

28. Place ot Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) end manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: 89398

29d. Date signed (Month, Day, Yeer): 11/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rashid Haq, m.d. c/o Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: Donna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Ronald Cadle

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38564

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FRED CIKER

2. Date of Death (Month, Day, Year): November 30 2001

3. Time of Death: 12:05 PM

4a. Facility Name *(If not institution, give street and number)*: 2303 MARYLAND AVENUE #310

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-32-1079

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV.29,1930

9. Birthplace *(State or Foreign Country)*: AUSTRIA

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2303 MARYLAND AVENUE #310

10f. Zip Code: 21218

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: NEVER WORKED

16b. Kind of Business/Industry: NEVER WORKED

17. Father's Name *(First, Middle, Last)*: NOAH CIKER

18. Mother's Name *(First, Middle, Maiden Surname)*: ANNA MUCK

19a. Informant's Name/Relationship *(Type, Print)*: RUTH CIKER / SISTER-IN-LAW

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1 POMONA EAST #103 - BALTIMORE, MD 21208

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHEVRA AHAVAS CHESED

Date: 12/3/01

20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Coronary Artery Disease — one year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D37928

29d. Date signed *(Month, Day, Year)*: December 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert K. Ruby MD 2435 West Belvedere Ave Baltimore MD 21215

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 2001

32. Registrar's Signature: [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 38565

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Albert F. Dumler

2. Date of Death (Month, Day, Year): December 3, 2001

3. Time of Death: 3:50pm

4a. Facility Name (If not institution, give street and number): VA Medical Center, Fort Howard, MD 21052

4b. City, Town, or Location of Death: Fort Howard

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-26-5563

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 01-11-1930

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Conowingo

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 781 Ragan Road

10f. Zip Code: 21928

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic

16b. Kind of Business/Industry: heavy Equipment

17. Father's Name (First, Middle, Last): Raymond J. Dumler

18. Mother's Name (First, Middle, Maiden Surname): Anna C. Hokamp

19a. Informant's Name/Relationship (Type, Print): Ann Anderson (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8435 Bay Road, Pasadena, MD. 21122

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro. Crematory, Inc.

Date: Dec. 04 2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD. 21122

To Be Completed by Funeral Director

Dumler, Albert F.
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LUNG CANCER — 4months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Anna C. Tan, M.D.

29c. License number: D14958

29d. Date signed (Month, Day, Year): Dec. 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Aurora Tan, MD - 9600 North Point Rd., Fort Howard, MD 21052

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38566

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rick Arlan DeWeese
2. Date of Death (Month, Day, Year): December 1, 2001
3. Time of Death: 10:22AM
4a. Facility Name (If not institution, give street and number): Joseph Richie Hospice
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-70-3892
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 38 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Jan 8, 1963
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3022 East Darby Street
10f. Zip Code: 21211
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter
16b. Kind of Business/Industry: Construction
17. Father's Name (First, Middle, Last): Larry W. DeWeese
18. Mother's Name (First, Middle, Maiden Surname): Mary Geraldine Morris
19a. Informant's Name/Relationship (Type, Print): Larry W. DeWeese/Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2906 Keswick Road, Baltimore, MD 21211
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory | Date: Dec 3 2001
20c. Location - City or Town, State: Beltsville, MD
21. Signature of Funeral Service Licensee: Stella Lohmann
22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acquired immune deficiency syndrome — 13 yrs
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hepatitis; Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [✓] Other (Specify) Hospice
27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Elizabeth Tso MD
29c. License number: D24170
29d. Date signed (Month, Day, Year): December 3, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elizabeth Tso MD Joseph Richey Hospice 820 N Eutaw St Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

December 1, 2001 10:22

Rick DeWeese

*

3

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38567

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: JOHN DiMARCANTONIO

2. Dete of Death (Month, Day, Year): NOV. 29, 2001

3. Time of Death: 10:30 pm

4a. Facility Neme *(If not institution, give street and number)*: 2831 MONTEBELLO TERRACE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-05-2208

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: SEPT. 2, 1916

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. Stete: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3710 FAIT AVENUE

10f. Zip Code: 21224

10g. Citizen of What Country?: U.S.A.

11. Merital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Yeer or Dates: 1945-46

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) / College (1-4or 5+): 1

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: INSPECTOR

16b. Kind of Business/Industry: BALTIMORE CITY

17. Father's Neme *(First, Middle, Last)*: GAETANO DiMARCANTONIO

18. Mother's Neme *(First, Middle, Maiden Surname)*: GENOVEFFA SCAGLIARINI

19a. Informant's Neme/Reletionship *(Type, Print)*: CRESCENTIA DiMARCANTONIO

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 3710 FAIT AVENUE, BALTIMORE, MARYLAND 21224

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Plece of Disposition *(Neme of cemetery, cremetory or other piece)*: SACRED HEART OF JESUS

Date: 12/3

20c. Location - City or Town, Stete: BALTIMORE, MARYLAND

21. Signeture of Funerel Service Licensee: [signature]

22. Neme and Address of Facility: LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTO., MD. 21224

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediete Cause (Finel diseese or condition resulting in death)

a. Atherosclerotic Cardiovascular disease

Due to (or as e consequence of):

b. Dilated Cardiomyopathy

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Last

Due to (or es e consequence of):

c. Emphysema

Due to (or es e consequence of):

d. Pulmonary Disease

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* Assisted Living Home

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier: [signature] Gene F. Dean, MD

29c. License number: D038 33

29d. Dete signed *(Month, Day, Year)*: 11/30/01

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): F. DEANNA 361 S. Highland Ave Balt. MD 21224

State Registrar

31. Date filed *(Month, Dey, Year)*: DEC 04 2001

32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

RR

RR 15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#23a per PHYG802 12/13/01 EW

Certificate of Death

Reg. No. 2001 38568

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIE MAE DAVIS
2. Date of Death (Month, Day, Year): NOVEMBER 30, 2001
3. Time of Death: 9:15 AM
4a. Facility Name (If not institution, give street and number): 754 RESERVOIR ST.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 250-32-3626
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5-20-1918
9. Birthplace (State or Foreign Country): SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 754 RESERVOIR ST.
10f. Zip Code: 21217
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): -12- | College (1-4or 5+): -0-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): RECEPTIONIST
16b. Kind of Business/Industry: HOUSING AUTHORITY

17. Father's Name (First, Middle, Last): EARLY SUMMERS
18. Mother's Name (First, Middle, Maiden Surname): BERTHA JONES

19a. Informant's Name/Relationship (Type, Print): PEGGIE MERCER(DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4406 CEDAR GARDEN RD. BALTIMORE, MARYLAND 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK
Date: 12-6-2001
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Jonath D. Hibner
22. Name and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiovascular failure
Due to (or as a consequence of):
b. ASCVD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D43472
29d. Date signed (Month, Day, Year): 12/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PETER CHIANG MD, 2425 EUTAW PL, BALTIMORE MD 21217

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: Brenda B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38569

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Corinne C Elliott

2. Date of Death (Month, Day, Year): November 24, 2001

3. Time of Death: 1:25AM

4a. Facility Name *(If not institution, give street and number)*: Good Samaritan Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 403-18-6101

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 7, 1921

9. Birthplace *(State or Foreign Country)*: Kentucky

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1907 Stanhope Road

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 Years | College (1-4or 5+):

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Ed Carter

18. Mother's Name *(First, Middle, Maiden Surname)*: Vestie Kinser

19a. Informant's Name/Relationship *(Type, Print)*: Phyllis Wilder (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 224 Nanticoke Road, Baltimore, MD 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Oak Lawn Cemetery

Date: 11/27/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Scott P. Gardner per DVR

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave., Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceusad the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease — 10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D0032548

29d. Date signed *(Month, Day, Year)*: November 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Perry Colvin MD. Baltimore VA Medical Center 10 North Greene St Baltimore

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 2001

32. Registrar's Signature: ▶ [signature] D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38570

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Blair Frawley
2. Date of Death (Month, Day, Year): DECEMBER 1 2001
3. Time of Death: 10:38 M
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 269-20-4065
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 22, 1926
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 710 Powhattan Beach Road
10f. Zip Code: 21122
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Korean WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Staff Sgt.
18b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Edward John Frawley
18. Mother's Name (First, Middle, Maiden Surname): Maude Blair

19a. Informant's Name/Relationship (Type, Print): Russ Roda
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 710 Powhattan Beach Road, Pasadena, MD 21122

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.
Date: 12/2/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Mitchell Stallings
22. Name and Address of Facility: Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE-ON-CHRONIC RENAL FAILURE
Due to (or as a consequence of):
b. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
c. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: D51664
29d. Date signed (Month, Day, Year): DECEMBER 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUDHIR KUMAR AGGARWAL M.D. NORTH ARUNDEL HOSPITAL 301 HOSPITAL DRIVE, GLEN BURNIE MD 21061

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: Donna P Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

FRAWLEY, BLAIR

12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38571

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Lasl): Amy M. Fisher
2. Deta of Death — Month: December Day: 3 Year: 2001
3. Time of Death: 4:05 pm
4a. Facility Nema (If not institution, give street and number): Charlestown Care Center
4b. City, Town, or Location of Death: Catonsville
4c. County ot Deeth: Baltimore

Funeral Director

5. Social Security Number: 478-46-1723
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dele of Birth (Month, Day, Year): Sept 19, 1910
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Arnold
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 629 Cove Terrace
10f. Zip Code: 21012
10g. Citizen of What Country?: United States

11. Merital Status: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No Specify:
14. Reca - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Guidance Counselor
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Ulysses S. McCauchey
18. Mother's Name (First, Middle, Maiden Surname): Amy Herrold

19a. Informent's Neme/Relelionship (Type, Print): Ann F. Walter - Daughter
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 629 Cove Terrace, Arnold, Maryland 21012

20a. Method ot Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stele 4☐ Donallon 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other place): Loudon Park Cemetery
Date: 12/5/01
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funerel Sarvice Licensee: [signature]
22. Nema end Addrass ot Fecility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused tha deeth. Do not enter the mode ot dying, such as cardiac or respiretory errest, shock, or heert teilure. List only one cause on eech line.

Approximete Intervel Between Onset and Death

Immediete Causa (Final disease or condition resulting in death)
a. End Stage Dementia — Years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b. Due to (or es a consequence of):
c. Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contributa to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to completion of cause ot death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Placa of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpalient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At homa, tarm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted.

29b. Signature end title of certifier: [signature] MD
29c. License number: D51051
29d. Data signed (Month, Day, Year): December 03, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andres Salazar 711 Maiden Choice Lane, Catonsville, MD, 21228

State Registrar

31. Data filed (Month, Day, Year): DEC 04 2001
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

& Name: Amy Fisher

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#23a perPHYG802 12/04/01 EM

Certificate of Death

Reg. No. 2001 38572

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
JAMIRA WANDA FORD			October 28, 2001	0115 M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
Sinai Hospital of Baltimore	Baltimore		N/A	

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
NA	1☐M 2☑F	Yrs.		1			10/26/01	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD		BALTIMORE	1☑Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7235 SAWMILL BRANCH RD	21244	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☑Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☑No If Yes, Give Year or Dates:	1☐Yes 2☑No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
NA		NA	NA

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ANTONIE FORD	WANDA WILSON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244
WANDA WILSON FORD	7235 SAWMILL BRANCH Rd, BALTO, MD

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☑Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	METRO	11-2-01	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Willie E Howell	HOWELL FUNERAL HOME 4600 LIBERTY HGTS AVE, BALTO, MD 21207

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Extreme Prematurity	30.5 hrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Pulmonary Hemorrhage	2hr 15 min
	Due to (or as a consequence of): c. ~~Birth Asphyxia~~	~~30.5 hrs~~
	Due to (or es a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D0032436	November 1, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Joseph M. Wiley, MD Sinai Hospital, 2401 W. Belvedere Ave, Baltimore, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	▶ Jennie B Sparks

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

BG Wilson

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38573

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
William Frederick Frei, Jr.	December 1, 2001	2346 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
7125 E. Furnace Branch Rd 1A	Glen Burnie, MD	Anne Arundel Co.

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-28-0407	1 [X] M 2 [ ] F	67 Yrs.			April 20, 1934	Balto, MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	A.A. County	Glen Burnie	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7125 E. Furnace Branch Rd, 1A	21060	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Contractor	Frei Engineering Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William F. Frei, Sr.	Emily Robinson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Barbara Killen (Companion)	7125 E. Furnace Branch Rd, Glen Burnie, MD 21060

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Glen Haven Cemetery	Dec. 5, 2001	Glen Burnie, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Dan P. Chartier	Kirkley-Ruddick F.H., PA, 421 Crain Hwy, SE Glen Burnie, MD 21060

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Cardiac Arrhythmia — minutes

Due to (or as a consequence of):

b. Arterio Sclerotic Heart Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1 [X] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ William R. Jones Deputy MD	D06054	12/3/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William P. Jones, MD 695 America 21035

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	▶ Penny D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38574

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
WARREN	FEWSTER	SR.	December 2, 2001	5:45 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Mercy Medical Center	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-09-0609	1 M 2 F	80 Yrs.			March 4, 1921	Md.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Dundalk	1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8241 Longpoint Road	21222	USA

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8 yrs.		Electrician Foreman	Railroad

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Edward W. Fewster	Margaret Schuler

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Warren Fewster Jr. Son	1622 Feldbrook Road, Baltimore, Md. 21286

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Oaklawn Cemetery	December 5, 2001	Dundalk, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Anthony C. Connelly	Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md 21222

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	one week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or es e consequence of): c.	
	Due to (or es e consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 3 Probably 4 Unknown	1 Yes 2 No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	
	28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D54569	December 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD SOHN MD, CARNEGIE 568, 600 N WOLFE ST, BALTIMORE, MD 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38575

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BETTE J. FELDMAN-DEITSCH
2. Date of Death (Month, Day, Year): NOVEMBER 29, 2001
3. Time of Death: 9:20 AM

4a. Facility Name *(If not institution, give street and number)*: 4743 MARYKNOLL ROAD
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-24-9474
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: SEP. 18, 1928
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4743 MARYKNOLL ROAD
10f. Zip Code: 21208
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: JAMES ARTHUR
18. Mother's Name *(First, Middle, Maiden Surname)*: ETHEL COHEN

19a. Informant's Name/Relationship *(Type, Print)*: EVAN FELDMAN / SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2824 QUARRY HEIGHTS WAY - BALTIMORE, MD 21209

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, cremetory or other place)*: ARLINGTON CHIZUK AMUNO — Date: 12/2/01
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: ▶ Edward C. Rund
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION — MINUTES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. TYPE 1 DIABETES — 60 YEARS

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residance 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ David H. Madoff
29c. License number: D31419
29d. Date signed *(Month, Day, Year)*: NOVEMBER 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID H. MADOFF, M.D., PHD GOOD SAMARITAN HOSPITAL - RUSSELL MORGAN BUILDING

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 2001
32. Registrar's Signature: Jeanne D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38576

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
MARY	GOODMAN-BARNES		11	30	2001	9:44 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HARBOR HOSPITAL CENTER	BALTIMORE	BALTIMORE CITY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-68-7331	1☐M 2☒F	47 Yrs.					Aug 22 1954	District of Columbia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	n/a	Brooklyn	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
833 Glade Court	21225	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Taxi Driver	Transportation

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Louis E. Goodman	Mary E. Giddings

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Gus M. Scardina / husband	833 Glade Court, Brooklyn, Maryland 21225

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Bayview Crematory	12/5/2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ANOXIC ENCEPHALOPATHY	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. MYOCARDIAL INFARCTION	24 hours
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one) — Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
		1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Kourosh Dibadj	P14426	NOVEMBER 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KOUROSH DIBADJ 3001 SOUTH HANOVER PARKWAY BALTIMORE MD 21225

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38577

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Vernon Ezell Grimsley, Sr.

2. Date of Death Month Day Year: Nov 29 2001

3. Time of Death: 7:43 a M

4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 220-28-8464

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 30 1929

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7879 Crilley Road Apt 455

10f. Zip Code: 21060

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic

16b. Kind of Business/Industry: City Government

17. Father's Name *(First, Middle, Last)*: Snowdy Herman Grimsley

18. Mother's Name *(First, Middle, Maiden Surname)*: Maggie Ellis

19a. Informant's Name/Relationship *(Type, Print)*: Barbara Weippert / daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1029 Phillip Drive, Glen Burnie, Maryland 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lake View Mem. Park

Date: 12/3/2001

20c. Location - City or Town, State: Sykesville, Maryland

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. congestive heart failure — 7 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. pneumonia — 7 1 week

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Liva birth 2 [ ] Fatal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other *(specify)* 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

hypertension

Chronic Obstructive lung disease

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ Robert T Peterson MD

29c. License number: D24804

29d. Date signed *(Month, Day, Year)*: 11/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Peterson MD AAMC Annapolis Md 21401

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 2001

32. Registrar's Signature ▶ Donna B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38578

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ella Elizabeth Gallion

2. Date of Death (Month, Day, Year): November 29 2001

3. Time of Death: 2201

4a. Facility Name *(If not institution, give street and number)*: St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: -

Funeral Director

5. Social Security Number: 215-07-5674

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 20, 1918

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 321 Whitfield Road

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: OWn Home

17. Father's Name *(First, Middle, Last)*: Louis Weinlich

18. Mother's Name *(First, Middle, Maiden Surname)*: Mamie Kroger

19a. Informant's Neme/Relationship *(Type, Print)*: Kathleen Gallion- daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1903 Oak Lodge Road, Catonsville, Md. 21228

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory | Date: 12/06/01

20c. Location - City or Town, State: Beltsville, Md

21. Signature of Funerel Service Licensee: Jonathan Schein

22. Name and Address of Facility: Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue, Catonsville, Md. 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. atherosclerotic coronary disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: high blood pressure

23b. Did tobacco use contributa to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturet 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or Investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated.

29b. Signeture and title of certifier: Jeannine Saunders MD

29c. License number: D33061

29d. Date signed *(Month, Day, Year)*: November 29 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Jeannine Saunders 900 Caton Avenue Baltimore

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 04 2001

32. Registrer's Signature: D Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Gallion, Ella

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38579

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
SARA RUTH GROSE	NOVEMBER 28, 2001	2:50p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ROLAND PARK PLACE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-54-8476	1☐M 2☒F	87 Yrs.			08/21/1914	KANSAS

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
830 WEST 40TH STREET	21211	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	HOMEMAKER	HOMEMAKER

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
GILBERT STEVENS COX	GERTRUDE SCHENCK

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
GEORGE R. GROSE(SON)	1412 LABELLE AVE. TOWSON,MD. 21204.

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	GREEN MOUNT CREMATORY	11/30/2001	BALTO.,MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ R.G. Russ	HENRY W. JENKINS AND SONS COMPANY 6500 YORK ROAD,BALTIMORE,MARYLAND,21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PELVIC ABSCESS	3 WEEKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA (ALZHEIMERS) SEVERE

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☒Yes 2☐No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residance 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Charles O'Donovan MD	D 12399	NOVEMBER 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES O'DONOVAN M.D.,6565 NORTH CHARLES ST.,TOWSON,MD.,21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	▶ Donna B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

A

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38580

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Irene G. Herron

2. Date of Death: Month November Day 28 Year 2001

3. Time of Death: 1:45pm

4e. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 239-34-3090

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): January 19, 1928

9. Birthplace (State or Foreign Country): N. Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3047 Huntingdon Avenue

10f. Zip Code: 21211

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: In Own Home

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Luther Herron Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3047 Huntingdon Avenue Baltimore, Maryland 21211

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Clingman Memorial Gardens

Date: 12/3

20c. Location - City or Town, State: Blacksburg, NC

21. Signature of Funeral Service Licensee: Stacy H Carpenter

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung cancer	3 months
	Due to (or as a consequence of):	
	b. Pneumonia	2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephanie Davis MD

29c. License number: AV4176435D13873

29d. Date signed (Month, Day, Year): November 28 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephanie L. Davis MD 201 East University Parkway Balt. MD 21218

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38581

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ida Hamilton
2. Date of Death (Month, Day, Year): 11-26-2001
3. Time of Death: 5:30AM
4a. Facility Name (If not institution, give street and number): 7506 Digby Road
4b. City, Town, or Location of Death: Woodlawn
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-50-0206
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05-30-1946
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Woodlawn
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7506 Digby Road
10f. Zip Code: 21207
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Balto. City

17. Father's Name (First, Middle, Last): Frank Harvin Sr.
18. Mother's Name (First, Middle, Maiden Surname): Edna Magwood

19a. Informant's Name/Relationship (Type, Print): Lensey E. Hamilton (husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7506 Digby Road Balto. MD. 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Arbutus Cemetery
Date: 12/01/01
20c. Location - City or Town, State: Balto, MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C Greene
22. Name and Address of Facility: Vaughn C Greene Funeral Svc. 5151 Balto. Nat'l Pike Balto. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Colon Cancer — 2 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ David A VanEchoMD
29c. License number: D0024532
29d. Date signed (Month, Day, Year): 11/28/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID A VAN ECHO MD ; 22 South Greene Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: Barbara P Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

RR

RR 15

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38582

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: KENNETH LUROY HAND

2. Date of Death Month Day Year: NOVEMBER 30, 2001

3. Time of Death: 7:20 PM

4a. Facility Name *(If not institution, give street and number)*: SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 506-36-2697

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 15, 1916

9. Birthplace *(State or Foreign Country)*: Nebraska

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Cockeysville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 10600 Al Partridge Lane

10f. Zip Code: 21030

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: District Manager

16b. Kind of Business/Industry: Utilities

17. Father's Name *(First, Middle, Last)*: John Clarence Hand

18. Mother's Name *(First, Middle, Maiden Surname)*: Gertrude May Boyer

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Mary F. Hand (wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10600 Al Partridge Ln. Cockeysville, MD 21030

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bayview Crematory

Date: Dec. 3, 2001

20c. Location - City or Town, State: Dundalk, Maryland

21. Signature of Funeral Service Licensee: Brian T. Chisholm

22. Name and Address of Facility: Brian T. Chisholm Funeral Services of Dulaney Valley, P.A. 200 E. Padonia Road, Timonium, Maryland 21093

Physician /Medical Examiner

26a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause *on* each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEVERE AORTIC STENOSIS — 6 MONTHS

Due to (or as a consequence of):

b. CONGESTIVE CARDIOMYOPATHY — 1 YEAR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE LUNG DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Beatriz P. Dizon, M.D.

29c. License number: D0016432

29d. Date signed *(Month, Day, Year)*: November 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BEATRIZ P. DIZON, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38583

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Thomas Harthausen	Nov 29 2001	2:00 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2120 Maisel Street	Morrell Park	n/a

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-44-7008	1 [X] M 2 [ ] F	54 Yrs.			Jan 28 1947	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	n/a	Morrell Park	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2120 Maisel Street	21230	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	Sign Designer	Manufacturing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Wilbert Harthausen	Elizabeth Raeke

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Shirley F. Harthausen / wife	2120 Maisel Street, Morrell Park, Maryland 21230

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Maryland Veterans Cem.	12/3/01	Crownsville, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	8 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypercalcemia of Malignancy

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] Wm C Waterfield MD	024356	November 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wm C WATERFIELD MD St Agnes Healthcare 900 Caton Ave Balt. Md 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38584

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
ANGELINE RICKERT HOEN	NOV. 30 2001	11:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ROLAND PARK PLACE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-22-8647	1☐M 2☒F	92 Yrs.					08/03/1909	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
830 WEST 40TH STREET	21211	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	TEACHER	EDUCATION

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
KEMP HOEN	KATHERINE RICKERT

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARY LOKER(ATTORNEY)	3421 SWEET AIR RD. PHOENIX,MD. 21131.

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	GREEN MOUNT	12/08/2001	BALTO.,MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ William K Baird III	HENRY W. JENKINS & SONS CO. 6500 YORK RD. BALTO.,MD. 21212.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Stroke	2 Weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Gregory L. Walker MD	D25662	12/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORY L. WALKER M.D. 3333 N. CALVERT ST. BALTO.,MD. 21218.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	▶ Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by tha attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

David Bryan Joyner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS #7 per fh G802 120401 sss

Certificate of Death

Reg. No. 2001 38585

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David Bryan Joyner

2. Date of Death (Month, Day, Year): November 29, 2001

3. Time of Death: 1200 PM

4a. Facility Name (If not institution, give street and number): 47A Oak Grove Drive

4b. City, Town, or Location of Death: Middle River

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-94-7722

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): ~~31~~ 32 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 28, 1969

9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 47A. Oak Grove Drive

10f. Zip Code: 21220

10g. Citizen of What Country?: USA

11. Meritel Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: Tree Removal

17. Father's Name (First, Middle, Last): Luther Earl Joyner Sr.

18. Mother's Name (First, Middle, Maiden Surname): Sharon Ann Jones

19a. Informant's Name/Relationship (Type, Print): Luther Earl Joyner Sr. Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3432 Liberty Parkway, Dundalk, Md. 21222

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory

Date: December 4, 2001

20c. Location - City or Town, State: Baltimore City, Md.

21. Signature of Funeral Service Licensee: [signature] M01096

22. Name and Address of Facility: Connelly Funeral HOme of Dundalk, P.A. 7110 Sollers POint Road, Dundalk, Md. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Gun shot Wound to Head — 5 minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): November 29, 2001

28b. Time of Injury: 1200 PM M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: self inflicted Gun shot wound to Head

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 47A Oak Grove Dr. Middle River, Md.

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 [X] Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD DePuty

29c. License number: D18667

29d. Date signed (Month, Day, Year): December 3, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): PHILIP Militello, MD Shock Trauma 225 Green ST. Baltimore, MD 21201

3

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RJD
SIDNEY L. JOYNER
01-6796-510

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38586

AMENDED ITEM#5 per fh G802 121101 ss

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sidney L. Joyner
2. Date of Death (Month, Day, Year): DECEMBER 01, 2001
3. Time of Death: 0247A.M.

4a. Facility Name (If not institution, give street and number): UNIVERSITY HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: ~~214-96-0447~~ 212-96-0447
6. Sex: 1☑M 2☐F
7. Age (In yrs. last birthday): 29 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9-30-72
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑Yes 2☐No
10e. Street and Number: 5106 Midwood Ave
10f. Zip Code: 21212
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☑Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sanitation
16b. Kind of Business/Industry: Sanitation

17. Father's Name (First, Middle, Last): Arthur Joyner
18. Mother's Name (First, Middle, Maiden Surname): Annie Mae Lee

19a. Informant's Name/Relationship (Type, Print): Arthur Joyner
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5106 Midwood Ave Balto. MD 21212

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Cemetery
Date: 12-6-01
20c. Location - City or Town, State: Baltimore

21. Signature of Funeral Service Licensee: ▶ Patricia Betts
22. Name and Address of Facility: Betts Funeral Home 1129 N. Caroline St Balto MD 21213

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Gunshot Wound of Chest
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☑Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☑Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☑Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year): 12-1-01
28b. Time of Injury: 0205 M
28c. Injury at Work? 1☐Yes 2☑No
28d. Describe how injury occurred: Subject Shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Street
28f. Location (Street and Number or Rural Route Number, City or Town, State): 500 Albemarle Ave

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): DECEMBER 01, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler, 111 Penn Street, Baltimore, Maryland 21201

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38587

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Lee Daniel Johnson	NOV 29, 2001	6:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2823 South Haven Road	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-32-3418	1 [X] M 2 [ ] F	65 Yrs.			APR 14, 1936	California

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Annapolis	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2823 South Haven Road	21401	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1958-1962	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Electronics Engineer	US Gov't. / NOAA

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Bill Lea Johnson	Peggy Florey

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joanne S. Johnson / wife	2823 South Haven Rd. Annapolis, MD 21401

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Metro Crematory, Inc.	11/30/01	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ George E. MacNabb	Cremation Society of MD, Inc 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner — **Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pyriform Sinus Cancer — 6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Dey, Year)
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Jeanine Werner MD	DS2830	November 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jeanine Werner 900 Bestgate Rd #300 Annapolis, MD 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	▶ Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38588

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Virginia Barnett Jackson	NOV 29 01	0815 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ST. AGNES HEALTHCARE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-10-4145	1 ☐ M 2 ☒ F	77 Yrs.			SEPT 6, 1924	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1 ☒ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
223 N. Culver Street	21229	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Phillip Barnett	Edna Carter

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Gloria Blair/daughter	10829 Sherwood Hill Road Owings Mills, MD 21117

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metro Crematory, Inc.	11/30/01	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Thomas Gregor	Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 1 YEAR.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CARDIOMYOPATHY, ATRIAL FIBRILLATION, EMPHYSEMA, PERIPHERAL VASCULAR DISEASE

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	28. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ B. Ofomata MD	P 15632	NOV - 29 - 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. ANAKWA, MD ST AGNES HOSPITAL, 900 CATON AVE, BALTIMORE MD 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	▶ Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME JACKSON, VIRGINIA
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38589

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NANCY KEARNS

2. Date of Death: Month DECEMBER Day 01 Year 2001

3. Time of Death: 1:47am

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 172-40-2331

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 21, 1948

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8479 Main Street

10f. Zip Code: 21122

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Paralegal

16b. Kind of Business/Industry: Law

17. Father's Name (First, Middle, Last): John Bodnar

18. Mother's Name (First, Middle, Maiden Surname): Sophia

19a. Informant's Name/Relationship (Type, Print): Kimberly K. Hessian (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 108 Bentons Pleasure Rd., Chester, MD 21619

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.

Date: Dec. 01 2001

20c. Location - City or Town, State: P.O. Box 2966 Baltimore, MD 21229

21. Signature of Funeral Service Licensee: Russell Stallings

22. Name and Address of Facility: Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS — one day

Due to (or as a consequence of):

b. LIVER AND LUNG METASTASIS — FOUR YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. BREAST CANCER — 1993-01

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: 13133

29d. Date signed (Month, Day, Year): December 01 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sohair Yousif Johns Hopkins Hospital 600 North Wolfe, Baltimore, Md

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38590

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Kennedy

2. Date of Death (Month, Day, Year): November 30, 2001

3. Time of Death: 10 AM

4a. Facility Name (If not institution, give street and number): Gilchrist Hospice @ GMBC

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 065-16-2123

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 06/04/1920

9. Birthplace (State or Foreign Country): New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4998 B. Dorsey Hall Dr. Unit 4

10f. Zip Code: 21042

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW 11

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Auditor

16b. Kind of Business/Industry: CPA Firm

17. Father's Name (First, Middle, Last): John Kennedy

18. Mother's Name (First, Middle, Maiden Surname): Theresa Carey

19a. Informant's Name/Relationship (Type, Print): Carol Kennedy- wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4998 B. Dorsey Hall Dr. Unit 4, Ellicott City, Md.

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory

Date: 12/06/01

20c. Location - City or Town, State: Beltsville, Md.

21. Signature of Funeral Service Licensee: Kirk Schlageter NHA

22. Name and Address of Facility: Witzke Funeral Home of Columbia, 5555 Twin Knolls Road, Columbia, Md. 21045

11/30/01 6:13 AM

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. BREAST CANCER — 5 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. Anthony Riley, MD

29c. License number: D25205

29d. Date signed (Month, Day, Year): November 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: Donna D Sparks

Division of Vital Records, P.O. Box 68760, Edward Kennedy

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38591

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edward John Kirchman

2. Date of Death Month Day Year: Nov. 28, 2001

3. Time of Death: 5:45 Pm M

4a. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital

4b. City, Town, or Location of Death: Silver Springs

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 363-18-4297

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 10, 1919

9. Birthplace *(State or Foreign Country)*: Michigan

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Dayton

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 13891 Tridelphi Mill Rd.

10f. Zip Code: 21036

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: aerospace Engineer

16b. Kind of Business/Industry: Aerospace

17. Father's Name *(First, Middle, Last)*: Frank J. Kirchman

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Auman

19a. Informant's Name/Relationship *(Type, Print)*: Frank Kirchman- son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7618 lake Shore Drive, Owings, Md.20736

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory

Date: 11/30/01

20c. Location - City or Town, State: Beltsville, Md.

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Witzke Funeral Home of Columbia 5555 Twin Knolls Road, Columbia, Md. 21045

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LIVER CANCER — WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other *(specify)* 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

28. Place of Death *(Check only one)*: Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ David B. Harding, MD

29c. License number: 035965

29d. Date signed *(Month, Day, Year)*: NOVEMBER 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID B. HARDING, MD 1811 PRINCE PHILIP DR. #300 OLNEY, MD 20832

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #10e&f PER FH G802 12/04/01 JH

Certificate of Death

Reg. No. 2001 38592

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
MORRIS	SOLOMON	KLAVAN	December	1	2001	2010 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sinai Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-34-9970	XX 1 M 2 F	88 Yrs.					DEC. 22, 1912	LITHUANIA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	XX 1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2424 DIANA ROAD ~~2434 W. BELVEDERE AVENUE~~	21209 ~~21215~~	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 Yes 2 XX No If Yes, Give Year or Dates:	1 Yes 2 XX No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
5+		SHOCHET	KOSHER FOOD

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)		
JOSHUA	KLAVAN	FEIGA	DEVORA	SHEFER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ROSE KLAVAN / WIFE	2424 DIANA ROAD - BALTIMORE, MD 21209

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 Cremation 3 XX Removal from State 4 Donetion 5 Other (Specify)	ERETZ HACHAIM CEMETERY	12/2/01	BEIT SHEMESH, ISRAEL

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Edward C. Rusak	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Aspiration pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown		
24a. Was an autopsy performed? 1 Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	

25. Was case referred to medical examiner? 1 Yes 2 X No	26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	RES000	December 1 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Amy Michelle Meister, DO Sinai Hospital of Baltimore

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Patient known as Klavan, Morris

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38593

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
CAROL	SUE	KRAMER	December 1, 2001	932A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sinai Hospital - Baltimore	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-40-2284	1☐ M 2☒ F	61 Yrs.			JAN. 14, 1940	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3707 GARDENVIEW ROAD	21208	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
5+		SPEECH PATHOLOGIST	EDUCATION

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JULIUS M. WAGHELSTEIN	ROSE SIEGEL

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MORTON D. KRAMER / HUSBAND	3707 GARDENVIEW ROAD - BALTIMORE, MD 21208

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	BALTIMORE HEBREW CEM.	12/3/2001	REISTERSTOWN, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Edward C. Rusnak	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Intracerebral Hemmorhage	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Thrombocytopenia	
	Due to (or as a consequence of):	
	c. T Cell Lymphoma	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Patrick McGinley M.D.	D 0054482	December 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Patrick McGinley M.D. 2401 West Belvedere Ave. Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	Barbara D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Known AS: Carol Kramer

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38594

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
JOHN BAXTER		LIGHTSEY	November 28, 2001	4:00 PM
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
The Johns Hopkins Hospital	Baltimore City			

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-52-6558	XX 1 M 2 F	53 Yrs.			09 01 48	FL

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4801 Crowson Ave	21212	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 XX No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7th grade	na	Unemployed	Unemployed

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Norris Johnson	Bertha Lightsey

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Bertha Lightsey-Mother	5715 Park Heights Ave, Baltimore Md 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Metro Crematory Inc.	12/4/01	Baltimore, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Glynn B Kuhn	March F/H West 4300 Wabash Ave, Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Multilobar Pneumonia	21 Days
Due to (or as a consequence of):	b. Fungemia	10 Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy.	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acquired Immune Deficiency Syndrome
Pericardial Effusion

23e. Did tobacco use contribute to the causa of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 3 Probably 4 X Unknown	1 X Yes 2 No	1 Yes 2 X No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Cameo Cozart MD	RES-000	NOVEMBER 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cameo Cozart 600 North Wolfe Street, Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	▶ Penny D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #19b PER FH G 802 12/04/01 JH **Certificate of Death** Reg. No. 2001 38595

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Anthony Ludwig, Sr.
2. Date of Death (Month, Day, Year): December 1st 2001
3. Time of Death: 03:50 Am
4a. Facility Name (If not institution, give street and number): St Agnes Healthcare
4b. City, Town, or Location of Death: Baltimore MD
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-16-5488
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 4, 1919
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Manchester
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 3691 Maple Grove Road
10f. Zip Code: 21102
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Evar In U.S. Armed Forcas? 1 X Yes 2 ☐ No If Yes, Give Yaar or Detas: 42-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired): Carpenter
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Anthony Charles Ludwig
18. Mother's Name (First, Middle, Meiden Surname): Katherine Brown

19a. Informant's Name/Relationship (Type, Print): Ms. Lori King/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3691 Maple ~~Grive~~ GROVE Road, Manchester, MD 21102

20a. Method of Disposition: 1 X Burial 2 ☐ Cramation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Veteran
Date: Dec 5 2001
20c. Location - City or Town, State: Owings Mills, MD

21. Signeture of Funerel Service Licensea: Styli D Lohmann
22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused tha death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseasa or condition resulting in deeth): a. Metastatic lung cancer to Brain — 18 months
Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immedieta cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Last:
b. Due to (or es a consequence of):
c. Due to (or es a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.: Chronic Obstructive Pulmonary disease

23b. Did tobacco uas contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 X Naturel 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Panding investigetion 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and mannar as stated. 2 ☐ Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to tha cause(s) and menner stated.

29b. Signature and title of certifier: Mutombo Kankonde, MD
29c. License number: D46704
29d. Data signad (Month, Day, Year): December 1st 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): MUTOMBO KANKONDE, ST AGNES HOSPITAL BALTIMORE MD

State Registrar

31. Data filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signeture: Donna P Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

LUDWIG, CHARLES

NAME

Kiesha Lewis
CJ
01-6745-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38596

UNPENDED 031302:ITEMS#23a,27,28a-f per ME G805 ss

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KEICHEA T'KEYAH LEWIS

2. Date of Death: Month November, Day 28, Year 2001

3. Time of Death: 08:20 A.M.

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-61-1517

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): Yrs. | If Under 1 Year: Months 2, Days 8 | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Sept. 20, 2001

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5112 Craig Avenue

10f. Zip Code: 21212

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A

16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Keith Lewis

18. Mother's Name (First, Middle, Maiden Surname): Tarji Wooden

19a. Informant's Name/Relationship (Type, Print): Latonya Lewis- Aunt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5112 Craig Avenue Baltimore, Maryland 21212

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Pk. Cem.

Date: 12/03/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Beta Nutter

22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in daath)
a. SUDDEN UNEXPECTED DEATH IN INFANCY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last
b.

Due to (or as a consequance of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case refarrad to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only ona): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending Investigation 6☒ Could not be datarmined

28a. Date of Injury (Month, Day Year): Found: 11-28-01

28b. Time of Injury: Found: 7:20a M

28c. Injury at Work? 1☐ Yas 2☒ No

28d. Dascribe how injury occurred: Unknown

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify): Found at home

28f. Location (Street and Number or Rural Route Number, City or Town, Stata): 5112 Craig Ave.,3rd fl., Balto., MD

29a. Certifiar (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and mannar as stated. 2☒ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. King MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): November 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: Stephanie D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38597

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Paul M. LaVardera

2. Date of Death Month Day Year: November 29, 2001

3. Time of Death: 1:30 PM

4a. Facility Name *(If not institution, give street and number)*: 5967 Glen Falls Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-46-8981

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV 5, 1946

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 5967 Glen Falls Avenue

10f. Zip Code: 21206

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: X

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Manager

16b. Kind of Business/Industry: Retail Store

17. Father's Name *(First, Middle, Last)*: Salvatore LaVardera

18. Mother's Name *(First, Middle, Maiden Surname)*: Estelle Sill

19a. Informant's Name/Relationship *(Type, Print)*: Paul A. LaVardera/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1622 Myamby Road Towson, MD 21286

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Metro Crematory Inc.

Date: 12-1-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause *on* each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEVERE CONGESTIVE HEART FAILURE — 1 YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Sodhi

29c. License number: D42014

29d. Date signed *(Month, Day, Year)*: NOVEMBER 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SURINDERPAL SODHI, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 2001

32. Registrar's Signature: Geneva J Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38598

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Zane Laycock

2. Date of Death: Month: Nov; Day: 30; Year: 2001

3. Time of Death: 1356

4a. Facility Name *(If not institution, give street and number)*: Oak Crest Care Center

4b. City, Town, or Location of Death: Parkville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 016-16-7599

6. Sex: 1 ☒ M 2 ☐ F (X)

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months; Days

If Under 24 Hrs.: Hours; Min.

8. Date of Birth *(Month, Day, Year)*: AUG 3, 1921

9. Birthplace *(State or Foreign Country)*: Nevada

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No (X)

10e. Street and Number: 8810 Walther Blvd. Apt. 2429

10f. Zip Code: 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married (X) 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes (S) 2 ☐ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No (S) *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales & Marketing

16b. Kind of Business/Industry: Industrial

17. Father's Name *(First, Middle, Last)*: Sephton Laycock

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Bye

19a. Informant's Name/Relationship *(Type, Print)*: Deane C. Laycock/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8810 Walther Blvd. Apt. 2429, Parkville, MD 21234

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation (X) 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc.

Date: 12-1-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic lung CA — Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown (X)

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No (X)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No (X)

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No (X)

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☒ Nursing Home (X) 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural (X) 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (X) 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: DO 3110

29d. Date signed *(Month, Day, Year)*: Nov 30th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeff Landeman 8800 Walther Blvd, Parkville MD 21234

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 2001

32. Registrar's Signature: Deneva D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Laycock, Zane 11/30/01 1:56pm

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar AMENDED 120401: ITEM#10g per fh G802 ss

Reg. No. 2001 38599

Patient known as Predensia McKay

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Predensia	Marianna	McKay	November	30	2001	8:36AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sinai Hospital of Baltimore	Baltimore City	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-25-3216	1☐M 2☒F	74 Yrs.					11 14 27	Jamaica

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Pikesville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
614 Cylburn Road	21208	Jamaica ~~U.S.A.~~

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9th grade	na	Home Maker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Samuel Llewellyn	Daisy Wallfall

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Hubert O. McKay-Husband	614 Cylburn Road, Pikesville, Md 21208

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Smithfield District	12/12/01	Jamaica West Moreland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Glynn L. Kelly	March F/H West 4300 Wabash Ave, Baltimore Md 21215

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Myocardial Infarction	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as e consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yas 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Diabetes Mellitus

23e. Did tobecco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

4

4

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete and place, end due to tha ceusa(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ David S. Lee MD	RES-000	

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)
David S. Lee, MD 2401 West Belvedere Baltimore MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	▶ Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Pregenais		Marianna		McKay					
212-25-3216		XX	74			11	14	27	Jamaica
									X
MD	Baltimore			Pikesville					
614 Cylburn Road				21208				U.S.A.	
XX			X		X			Black	
9th grade		na		Home Maker			Own Home		
Samuel Llewellyn				Daisy Wallfall					
Hubert O. McKay-Husband				614 Cylburn Road, Baltimore, Md 21208					
XX									Jamaica
Smithfield District 12/12/01 West Moreland									
March F/H West				1300 Wabash Ave, Baltimore Md 21215					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38600

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Matthew F. Meyers

2. Date of Death: Month Dec. Day 2 Year 2001

3. Time of Death: 9:15 AM

4a. Facility Name (If not institution, give street and number): Gilchrist Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-03-2205

6. Sex: 1☐ M 2☐ F — X

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 9 1916

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1825 Landrake Rd.

10f. Zip Code: 21204

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Time Study Analyst

16b. Kind of Business/Industry: Accounting

17. Father's Name (First, Middle, Last): Christopher Meyers

18. Mother's Name (First, Middle, Meiden Surname): Pauline C. Mentis

19a. Informant's Name/Relationship (Type, Print): Annette Silverman/sister-in-law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1825 Landrake Rd., Towson, MD 21204

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery — Date: 12/5/01

20c. Location - City or Town, State: Pikesville, MD

21. Signature of Funeral Service Licensee: Bryan W. Clary

22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multi infart Dementia — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Afib

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Helen M Gordon

29c. License number: D0051926

29d. Date signed (Month, Day, Year): December 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen M Gordon MD 6565 N. Charles St Baltimore MD 21204

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: Brenda D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Meyers, Matthew 12.3.01 9:15am

10T1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38601

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Betty Jane Murphy
2. Date of Death (Month, Day, Year): November 28, 2001
3. Time of Death: 10:35 PM
4a. Facility Name (If not institution, give street and number): Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 234-34-3282
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 4, 1919
9. Birthplace (State or Foreign Country): West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 830 Wellington Street
10f. Zip Code: 21211
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: In Own Home
17. Father's Name (First, Middle, Last): George William Keaton
18. Mother's Name (First, Middle, Maiden Surname): Nancy Elizabeth Garrett
19a. Informant's Name/Relationship (Type, Print): Mrs. Eileene Justice Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3939 Roland Avenue #L4 Baltimore, MD 21211
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore-Washington Crematory
Date: 12/3/01
20c. Location - City or Town, State: Laurel, Maryland
21. Signature of Funeral Service Licensee: Stacey H. Carpenter
22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. sepsis	24 hrs
Due to (or as a consequence of):	b. pneumonia	2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last — Due to (or as a consequence of):	c. pancreatitis	2 weeks
Due to (or as a consequence of):	d. perforated bowel	4 weeks

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature end title of certifier: Jane Wilson, MD
29c. License number: AT 2438946
29d. Date signed (Month, Day, Year): November 28, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jane Wilson Union Memorial Hospital, 201 E. University Parkway, Baltimore, MD 21218

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38602

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Delila Middleton

2. Date of Death: Month November Day 20 Year 2001

3. Time of Death: 3:11pm

4a. Facility Name *(If not institution, give street and number)*: Gladys Spellman Nursing Home

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 579-24-1740

6. Sex: 1☐ M 2☒ F

7. Age *(in yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 08, 1916

9. Birthplace *(State or Foreign Country)*: Newburg, MD.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George

10c. City, Town or Location: Capitol Heights

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 266 Possum Court

10f. Zip Code: 20743

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Beautician

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Guy Washington

18. Mother's Name *(First, Middle, Maiden Surname)*: Eliza Ford

19a. Informant's Name/Relationship *(Type, Print)*: Theresa Chase/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 266 Possum Court, Capitol Heights, MD. 20743

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lincoln Memorial Park

Date: 11/28/01

20c. Location - City or Town, State: Suitland, MD.

21. Signature of Funeral Service Licensee: Robert Thompson II

22. Name and Address of Facility: Pope Funeral Homes, 5538 Marlboro Pike, Forestville, MD. 20747

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure/ List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia

Due to (or as a consequence of):

b. Congestive Heart Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d. Hemiplegia

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Cumerbatch

29c. License number: D27577

29d. Date signed *(Month, Day, Year)*: 12/4/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Cumerbatch, MD Mercy Ln. Cheverly, MD. 20748

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38603

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Louise Janet Mines

2. Data of Death Month Day Year: November 11, 2001

3. Time of Death: 4:58am

4a Facility Name *(If not institution, give street and number)*: Doctors Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-52-4789

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: Nove. 14,1936

9. Birthplace *(State or Foreign Country)*: Washington,D.C.

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Forestville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2505 New Glen Ave.

10f. Zip Code: 20747

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Alphonzo Clark

18. Mother's Neme *(First, Middle, Meiden Surname)*: Bertha Thomas

19a. Informent's Name/Ralationship *(Type, Print)*: Renita A. Mines/ Daughter

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 2140 Alice Ave. #103 Oxon Hill, Md. 20745

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Ft. Lincoln Cem.

Date: 11/20/01

20c. Location - City or Town, Stete: Brentwood, Md.

21. Signature of Funerel Service Licensee: Kathy A. Lange MO1185

22. Neme end Address of Feciliity: Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Deeth

Immediete Ceuse (Final disease or condition resulting in death)

a. Respiratory Failure — Minutes.

Due to (or as a consequence of):

b. End Stage Renal Disease — Years.

Sequentielly list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury thet initiated evants resulting in death) Last

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Aspiration Pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of exemination end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and mannar steted.

29b. Signature and title of certifier: Sidhartha Pani

29c. Licanse number: D 0057308

29d. Dete signed *(Month, Day, Year)*: November 14, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Sidhartha Pani, M.D. 7253B Hanover Pkwy. Greenbelt, Md. 20770

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 04 2001

32. Registrer's Signeture: Teresa D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

RR

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38604

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Milton Martin, Jr.

2. Date of Death (Month, Day, Year): November 24, 2001

3. Time of Death: 2:56am

4a. Facility Name (If not institution, give street and number): Prince Georges Hospital

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 578-88-5841

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 27 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 30, 1974

9. Birthplace (State or Foreign Country): Washington,DC.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Mitchellville

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 718 Streamside Drive

10f. Zip Code: 20721

10g. Citizen of What Country? United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Food Service

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Milton Martin, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Yvonne James

19a. Informant's Name/Relationship (Type, Print): Yvonne Martin/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 718 Streamside Dr. Mitchellville, MD. 20721

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Huntt Crematory

Date: 12/3/01

20c. Location - City or Town, State: Waldorf, MD.

21. Signature of Funeral Service Licensee: Richard Thompson II

22. Name and Address of Facility: Pope Funeral Homes, 5538 Marlboro Pike Forestville, MD. 20747

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Severe bradycardia — hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Septic shock — days

Due to (or as a consequence of):

c. Bilateral Pneumonia — days

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute renal failure

Bilateral pulmonary embolism

Acute respiratory failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R Rustagi MD

29c. License number: D 24720

29d. Date signed (Month, Day, Year): 11/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 6132 Landover Rd/ Cheverly, MD 20785

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38605

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cyrus Hall McCormick Sr
2. Date of Death (Month, Day, Year): November 29, 2001
3. Time of Death: 7:05 M
4a. Facility Name (If not institution, give street and number): 5618 Mansfield Drive
4b. City, Town, or Location of Death: Camp Spring
4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 243-22-0758
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 23, 1925
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George
10c. City, Town or Location: Camp Spring
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5618 Mansfield Drive
10f. Zip Code: 20748
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mail Handler
18b. Kind of Business/Industry: Amtrak

17. Father's Name (First, Middle, Last): Neil A. McCormick
18. Mother's Name (First, Middle, Maiden Surname): Cardelia Murphy

19a. Informant's Name/Relationship (Type, Print): Larry McCormick- Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5618 Mansfield Drive Camp Spring MD 20748

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery
Date: 12-7-2001
20c. Location - City or Town, State: Brentwood Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ft. Lincoln Funeral Home 3401 Bladensburg Road Brentwood MD 20722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Emphysema — Approximate Interval Between Onset and Death: 12 Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b. Cardiopulmonary Failure — 4 Months
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Stroke
Failure to Thrive

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 [ ] Medical Examiner: On the besis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] Gary W. Jones MD
29c. License number: D30111
29d. Date signed (Month, Day, Year): December 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary W. Jones MD 4714 Colonel Ewell Court Upper Marlboro MD 20722-5925

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg No. 2001 38606

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas Mastovich

2. Date of Death: Month 11 Day 29 Year 2001

3. Time of Death: 902 A M

4a. Facility Name (If not institution, give street and number): University of Maryland Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 198 20 0231

8. Sex: 1 ☑ M 2 ☐ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 4/21/1928

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: PA

10b. County: Cumberland

10c. City, Town or Location: Enola

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 63 Rear Autumn

10f. Zip Code: 17025

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No — If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Contract Negotiator

16b. Kind of Business/Industry: Commonwealth of PA

17. Father's Name (First, Middle, Last): Dragich Mastovich

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Karaffa

19a. Informant's Name/Relationship (Type, Print): Mr. John Mastovich/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3194 Everly Court, Murrysville, PA 15668

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory

Date: Dec. 1, 2001

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Stephen Johnson

22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Sepsis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23f. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No

28. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: P15971

29d. Date signed (Month, Day, Year): 11/29/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Todd L. Siesinger MD, 22 South Greene St, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: Steven D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38607

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Lillian Myers	November 28, 2001	1:50 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland Hospital	Baltimore	Baltimore City

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-32-9306	1☐ M 2☒ F	64 Yrs.			9-3-1937	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4112 MOUNTWOOD RD.	21229	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
-12-	-2-	CERTIFIED NURSING ASSISTANT	HEALTHCARE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CARROLL PROCTOR SR.	LOIS WATERS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
WANDA HARRIS (DAUGHTER)	3412 W. CATON AVE. BALTIMORE, MARYLAND 21229

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	ARBUTUS MEMORIAL PARK	12-3-2001	BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Tarantha D. Hubner	PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Subarachnoid Hemorrhage	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnent at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

None

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at tha time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ M.D.	P15949	November 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert F. James, M.D. 22 South Greene Street Baltimore, M.D.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	▶

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #19b PER FH G802 12/04/01 JH

Certificate of Death

Reg. No. 2001 38608

Pt known as Freda Millison

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
FREDA		MILLISON	November 28, 2001	2:21 PM
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
SINAI HOSPITAL	BALTIMORE		N/A	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-16-6960	1☐M 2☒F	86 Yrs.			JAN. 1, 1915	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7218 PARK HEIGHTS AVENUE	21208	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
12		OWNER	COLLECTION AGENCY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
SAMUEL M. SUSKIN	IDA SIEGEL

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SCOTT MILLISON / SON	16 ~~WEST SPRINGWAY~~ WESTSPRING WAY - LUTHERVILLE, MD 21093

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	BETH TFILOH CEMETERY	11/30/2001	WOODLAWN, MD

21. Signature of Funeral Service Licensee ▶ Jay Allan Levin

22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebral Hemorrhage	6 Hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Hypertension	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Steven L. Joffe MD	D25379	November 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Steven L. Joffe Sinai Hospital, 2142 W. Belvedere Ave, Baltimore, Md. 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	Deputy D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed/filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38609

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Florence MaJor
2. Date of Death Month - Day - Year: 11 - 29 - 01
3. Time of Death: 5:00P M
4a. Facility Name (If not institution, give street and number): JoHns HopKins HospiTal
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-14-2687
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 93 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5-2-08
9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 633 Asquith St. apt 9E
10f. Zip Code: 21202
10g. Citizen of What Country? U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook
18b. Kind of Business/Industry: Food Industry

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Kate FaulKner

19a. Informant's Name/Relationship (Type, Print): Mary Jackson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 633 ASquith St Apt 9E Balto MD 21202

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial PK
Date: 12-5-01
20c. Location - City or Town, State: Baltimore

21. Signature of Funeral Service Licensee: Patricia Betts
22. Name and Address of Facility: Betts Funeral Home 1129 N. Caroline St Balto MD 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. atherosclerotic cardiovascular disease — 10 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Selovich, MD
29c. License number: D19838
29d. Date signed (Month, Day, Year): 11/30/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stuart E. Selovich, M.D. 900 Bestgate Rd. Annapolis, Md 21401

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: Donna D Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #20b&c PER FH G802 12/11/01 JH **Certificate of Death**

Reg. No. 2001 38610

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William McDONALD JR.

2. Date of Death (Month, Day, Year): November 30, 2001

3. Time of Death: 12:23 Am

4a. Facility Name (If not institution, give street and number): Baltimore V.A. Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-58-4420

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 49 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 17, 1952

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1803 Ashburton St.

10f. Zip Code: 21216

10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dry Wall Installer

16b. Kind of Business/Industry: Private Firm

17. Father's Name (First, Middle, Last): William McDonald Sr.

18. Mother's Name (First, Middle, Maiden Surname): Dorothy Pinnock

19a. Informant's Name/Relationship (Type, Print): (Sister) Ms. Gwen McDonald

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3308 N. Hilton St. Balto. Md. 21216

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST CEMETARY unk

Date: 12/12/01

20c. Location - City or Town, State: OWINGS MILL, MD. unk

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Sepsis	2 Days
Due to (or as a consequence of): b.	Lymphoma	6 Months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Acquired Immunodeficiency Syndrome	9 Years
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Vladimir Ioffe, M.D.

29c. License number: P 15764

29d. Date signed (Month, Day, Year): November 30, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Vladimir IOFFE, M.D. BVAMC 10 North Greene Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: Bernice B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

218-58-4420

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38611

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward C Nelson
2. Date of Death (Month, Day, Year): November 29 2001
3. Time of Death: 12:35p
4a. Facility Name (If not institution, give street and number): 3521 Edmondson Ave
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 213-07-5298
6. Sex: 1 XX M 2 ☐ F
7. Age (In yrs. last birthday): 97 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06 14 04
9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3521 Edmondson Ave
10f. Zip Code: 21229
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th grade
College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steelside
18b. Kind of Business/Industry: Bethlehem Steel Corp

17. Father's Name (First, Middle, Last): Lawrence Rainey Nelson
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Rush

19a. Informant's Name/Relationship (Type, Print): Marguerite McGlothlin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3521 Edmondson Ave, Baltimore Md 21229

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: 12/4/01
20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: Wayne D Keke
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Prostate Cancer — Approximate Interval Between Onset and Death: Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Alan Reisinger MD
29c. License number: D30631
29d. Date signed (Month, Day, Year): 12/3/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alan Reisinger III MD 700 Geipe Rd Catonsville, MD 21228

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: Steven D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CPM
01-6082-033
MELVIN NELSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 011502:ITEMS#23a,27 per ME G803 ss

Certificate of Death

Reg. No. 2001 38612

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Melvin Nelson	OCTOBER 26, 2001	17:20 M

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
967 ST. MICHAEL'S DRIVE	LARGO	PRINCE GEORGE'S

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
431-92-4985	1☒M 2☐F	53 Yrs.			April 28, 1948	AR

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Mitchellville Maryland	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
967 St. Michael's Drive	20721	United States

11. Maritel Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12	5+	CPA	Univ. Finance Office

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surname)
Louis Nelson	Dorothy Scott

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Minnie Hayes / Mother	1000 Weldon Road Newport AR 72112

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☐Buriel 2☐Cremation 3☒Removal from State 4☐Donetion 5☐Other (Specify)	Gum Grove Cemetery	November 30, 2001	Newport AR

21. Signature of Funeral Service Licensee ▶ Victor P. Doda, Jr.

22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lasl
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the pasl 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of deeth 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probebly 4☑Unknown

24a. Was an autopsy performed? 1☑Yes 2☐No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Wes case referred to medical examiner? 1☒Yes 2☐No	26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) SCENE

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.
2☒ **Medical Examinar:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Thomas Bruce Hullinan	O.C.M.E.	OCTOBER 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
M DAYDAVID A. KOREN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
DEC 04 2001	▶ G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Joseph Palmer, December 1, 2001, 12:05 P.M.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38613

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Palmer
2. Date of Death (Month, Day, Year): 12-01-2001
3. Time of Death: 12:05 PM
4a. Facility Name (If not institution, give street and number): Gilcrest Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-36-0750
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03-08-1939
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 1648 Warwick Ave
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Meat Cutter
16b. Kind of Business/Industry: Giant Food

17. Father's Name (First, Middle, Last): Joseph P. Palmer
18. Mother's Name (First, Middle, Maiden Surname): Maude Brown

19a. Informant's Name/Relationship (Type, Print): Marsha Palmer (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1648 Warwick Ave. Balto. MD. 21216

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. Zion Cemetery
Date: 12/8/01
20c. Location - City or Town, State: Lansdowne, MD

21. Signature of Funeral Service Licensee: Vaughn C Greene
22. Name and Address of Facility: Vaughn C. Greene Funeral Svc. 5151 Balto. Nat'l Pike Balto. MD. 21229

To Be Completed by Funeral Director

Joseph Palmer, December 1, 2001
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) hospice

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Helen M Gordon
29c. License number: D0051926
29d. Date signed (Month, Day, Year): December 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen M. Gordon 6565 N. Charles St. Baltimore MD 21204

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR

RR 8

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38614

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HUGH PYLE

2. Date of Death: Month November Day 28 Year 2001

3. Time of Death: 10^05 4 M

4a. Facility Name (If not institution, give street and number): Lorien Nursing Home

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 129-14-9657

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCt.29,1925

9. Birthplace (State or Foreign Country): new York

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4113 Red Bandana Way

10f. Zip Code: 21042

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944 1952

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steel worker

16b. Kind of Business/Industry: steel erection

17. Father's Name (First, Middle, Last): Jack Pyle

18. Mother's Name (First, Middle, Meiden Surname): Eva Hulance

19a. Informant's Name/Reletionship (Type, Print): Audrey Erickson Pyle- wife

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 4113 Red Bandana Way, Ellicott City, Maryland 21042

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Chesapeak e Crematory

Date: 12/03/01

20c. Location - City or Town, State: Beltsville, Md.

21. Signature of Funeral Service Licensee: Kim Schlanger MD 20/

22. Name and Address of Facility: Witzke Funral Home of Columbia 5555 Twin Knolls Road, Columbia, Md/ 21045

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 40 hours

Immediate Cause (Finat disease or condition resulting in death)

a. pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

Due to (or as a consequence of):

b. CAD

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

pneumathorax

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

26a. Date of Injury (Month, Day Year)

26b. Time of Injury M

26c. Injury at Work? 1 [ ] Yes 2 [ ] No

26d. Describe how injury occurred

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26f. Location (Straet and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D42465

29d. Date signed (Month, Day, Yeer): December 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Sammy MD 2knoll north Dr. Columbia MD 21045

State Registrar

31. Date filed (Month, Day, Year): DEC 0 4 2001

32. Registrar's Signature: D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23e or 26e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38615

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DONALD E. PLUMMER, SR.

2. Date of Death — Month: DEC Day: 2 Year: 2001

3. Time of Death: 01:15PM

4a. Facility Name *(If not institution, give street and number)*: Lorien Nursing Rehabilitation Center

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 215-22-8365

6. Sex: 1 ☐ M 2 ☒ F

7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JUNE 4, 1928

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 6260 Foreland Garth Apt. F

10f. Zip Code: 21045

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: 1946-1948

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Service Manager

16b. Kind of Business/Industry: Automotive

17. Father's Name *(First, Middle, Last)*: Leonard Earle Plummer, Jr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Mabel Gertrude Seward

19a. Informant's Name/Relationship *(Type, Print)*: Jacqueline Marcella Jansen/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10384 Tuscany Road Ellicott City, MD 21042

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Woodlawn Cemetery

Date: 12-5-01

20c. Location - City or Town, State: Woodlawn, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

Dawn F. McDonald

22. Name and Address of Facility: MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. LUNG CARCINOMA — MONTHS

Due to (or as a consequence of):

b. ANEMIA — MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. DIABETES MELLITUS — MONTHS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: SHUPE MD

29c. License number: D0053150

29d. Date signed *(Month, Day, Year)*: DEC 3rd 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHANNMALA GUPTA 201-109 BACK RIVER NECK RD 21221 BALTIMORE

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 2001

32. Registrar's Signature: Geneva D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38616

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DORIS L. PLITT

2. Date of Death Month / Day / Year: NOV 27 2001

3. Time of Death: 21:40 M

4a. Facility Name *(If not institution, give street and number)*: HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death: COLUMBIA

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 212-03-6018

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 11/23/1908

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 9309 Joey DR

10f. Zip Code: 21042

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

18b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Hiram John Dougherty Latchford

18. Mother's Name *(First, Middle, Maiden Surname)*: Pearl Gertrude Wise

19a. Informant's Name/Relationship *(Type, Print)*: Jan Davis/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9309 Joey DR Ellicott City, MD 212042

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park Cemetery

Date: 12/01/2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: John Sterling

22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ISCHEMIC CARDIOMYOPATHY — 2 WEEKS

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other *(specify)* 9☐Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D39629

29d. Date signed *(Month, Day, Year)*: NOV 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALEXANDER SY, M.D. 10724 LITTLE PATUXENT PARKWAY #200 COLUMBIA MD 21044

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 2001

32. Registrar's Signature: Geneva D Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

DHMH 17 Rev 1/2001

ORIGINAL

01-6695-510
mnmr
Lori Pennington

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 122001: ITEMS #23a, 27, 28a-f per ME G802 ss

Certificate of Death

Reg. No. 2001 38617

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
LORI JUNE PENNINGTON	November 25, 2001	1307 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Bayview Medical Center	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-88-4344	1☐M 2☒F	32 Yrs.			MAY 25, 1969	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
703 S. BOULDIN STREET	21224	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
☒☒Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		N/A	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
RAYMOND A. PENNINGTON	NANCY JUNE VIA

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
NANCY PENNINGTON/MOTHER	703 S. BOULDIN STREET, BALTIMORE, MD. 21224

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	BAYVIEW CREMATORY	12/1/01	BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. NARCOTIC AND ALCOHOL INTOXICATION	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☒Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

Medical Certification; To Be Completed by Physician/Medical Examiner

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accidant 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined	Found: 11-25-01	Unknown M	1☐Yes 2☒No	Unknown
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Found: Residence			703 S. Boulden St., Balto., MD

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature], M.D.	O.C.M.E.	November 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38618

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen M Rogers

2. Date of Death (Month, Day, Year): December 3, 2001

3. Time of Death: 12:30 pm

4a. Facility Name *(If not institution, give street and number)*: Gilchrist Center for Hospice Care

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 169-14-7469

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Apr 28, 1919

9. Birthplace *(State or Foreign Country)*: PA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Towson

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 1055 West Joppa Road #621

10f. Zip Code: 21204

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Olin R Mullison

18. Mother's Name *(First, Middle, Maiden Surname)*: Maude Rozell

19a. Informant's Name/Relationship *(Type, Print)*: Elsie R Davis/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8223 Rider Avenue, Towson, MD 21204

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory

Date: Dec 5 2001

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Stephen D Lohmann

22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. COPD — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Helen M Rogers

29c. License number: D0051926

29d. Date signed *(Month, Day, Year)*: December 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen M. Gordon 6565 N. Charles St, Baltimore MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 2001

32. Registrar's Signature

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Rogers, Helen 12-3-01 @ 12:40pm

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38619

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY E. ROCK
2. Date of Death (Month, Day, Year): DECEMBER 3, 2001
3. Time of Death: 4:00 A.M.
4a. Facility Name (If not institution, give street and number): 8627 BLACK OAK ROAD
4b. City, Town, or Location of Death: RIDGELEIGH
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-03-8035
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5/17/1914
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: RIDGELEIGH
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8627 BLACK OAK ROAD
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10TH GRADE — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BOOKKEEPER
16b. Kind of Business/Industry: FURNITURE STORE

17. Father's Name (First, Middle, Last): ANDREW E. PHFISTER
18. Mother's Name (First, Middle, Maiden Surname): ROSE M. YOUNG

19a. Informant's Name/Relationship (Type, Print): CHARLES E. MAHLA NEPHEW
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 230 STABLERS CHURCH RD. PARKTON, MD 21120

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY
Date: 12/6/01
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: ▶
22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial Infarction — < 1 hr.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robert E. Stamler MD
29c. License number: D0013272
29d. Date signed (Month, Day, Year): 12-3-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert E. Stamler MD Suite 403 7505 Osler Dr. Towson, Md. 21204

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: ▶ D Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR 5

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM#4a per phys G802 12040[illegible] SS

Certificate of Death

Reg. No. 2001 38620

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Daisy Richardson

2. Date of Death Month: November Day: 30 Year: 2001

3. Time of Death: 12:17 AM

4a. Facility Name (If not institution, give street and number): ~~3811 Granada~~ 3811 Granada Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 243-42-4365

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 2, 1930

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 3811 Granada Ave.

10f. Zip Code: 21215

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self-employed

16b. Kind of Business/Industry: Grocery

17. Father's Name (First, Middle, Last): Isiah Harlee

18. Mother's Name (First, Middle, Maiden Surname): Callie Thompson

19a. Informant's Name/Relationship (Type, Print): Rev. James McEachin (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3012 Baker St. Balto. Md. 21216

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cem. Date: 12/6/2001

20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Renal Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Diabetes Mellitus

Due to (or as a consequence of):

d.

If FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Donald Boesel, MD

29c. License number: D36757

29d. Date signed (Month, Day, Year): November 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Don Boesel 2411 W. Belvedere Ave Baltimore, Md 21215

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #5 PER FH G802 12/04/01 JH

Certificate of Death

Reg. No. 2001 38621

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNA RODMAN

2. Date of Death (Month, Day, Year): DECEMBER 1,2001

3. Time of Death: 6:00 PM

4a. Facility Name (If not institution, give street and number): 7 SLADE AVENUE #217

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: ~~219-14-1301~~ 820-02-9248

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 101 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAR.6,1900

9. Birthplace (State or Foreign Country): D.C.

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 7 SLADE AVENUE #217

10f. Zip Code: 21208

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): SAMUEL COHEN

18. Mother's Name (First, Middle, Maiden Surname): IDA SANDLER

19a. Informant's Name/Relationship (Type, Print): MILDRED GROSSMAN / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4001 OLD COURT ROAD #404 - BALTIMORE, MD 21208

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): BALTIMORE HEBREW CEM.

Date: 12/3/01

20c. Location - City or Town, State: REISTERSTOWN, MD

21. Signature of Funeral Service Licensee: Scott M. Cutler

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. septic shock — 12 hours

Due to (or as a consequance of):

b. sacral decubitus — 14 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. cerebrovascular accident — 4 months

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Richard C Beg, MD

29c. License number: D20604

29d. Date signed (Month, Day, Year): 12/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard A. Beg, MD #450, 10755 Falls Rd, Lutherville, Md 21093

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38622

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ruth K. Stroh

2. Date of Death — Month: Dec. Day: 3 Year: 2001

3. Time of Death: 11:05 AM

4a. Facility Name *(If not institution, give street and number)*: Gilchrist

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-26-4334

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Apr. 9 1927

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Cockeysville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 600 Sherwood Rd.

10f. Zip Code: 21030

10g. Citizen of What Country?: USA

11. Meritat Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- tt Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - Americen Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+): 5

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher

16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Thomas E. Stroh

18. Mother's Name *(First, Middle, Maiden Sumame)*: Sophia E. Menzel

19a. Informant's Name/Relationship *(Type, Print)*: Alan W. Kempske/nephew

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 147, Phoenix, MD 21131

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Entombment Dulaney Valley Mausoleum

Dete: 12/5/01

20c. Location - City or Town, State: Timonium, MD

21. Signature of Funeral Service Licensee: Lowell M. Lemmon

22. Name and Address of Facility: Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in deeth): a. Breast cancer — years

Due to (or as a consequence of):

Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last:

b. Due to (or es e consequenca ot):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Pert I.

HTN, OM, CHF

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the causa(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete and placa, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Helen M Gordon

29c. License number: D0051926

29d. Dete signed *(Month, Day, Year)*: December 3, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Helen M. Gordon, M.D. 6565 N. Charles St., Balto., MD 21204

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 04 2001

32. Registrar's Signature: D Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Stroh, Ruth 12-3-01 1105AM

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38623

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Sherman
2. Date of Death: Month December Day 2 Year 2001
3. Time of Death: 9:50 AM
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-56-5505
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 50 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6-30-51
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1436 N. Milton Ave
10f. Zip Code: 21213
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Human Resources
16b. Kind of Business/Industry: State of MD

17. Father's Name (First, Middle, Last): James Sherman
18. Mother's Name (First, Middle, Maiden Surname): Evelyn Stevens

19a. Informant's Name/Relationship (Type, Print): Marlow Sherman
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2802 Kennedy Ave Balti. MD 21212

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Pk
Date: 12-8-01
20c. Location - City or Town, State: Baltimore

21. Signature of Funeral Service Licensee: ▶ Patricia Betts
22. Name and Address of Facility: Betts Funeral Home 1129 N. Caroline St Balto. MD 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Metastatic laryngeal cancer — Approximate Interval: 7 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

anemia
Stricture stenosis of esophagus

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
28. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): December 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Johns Hopkins Hospital 600 North Wolfe Street Baltimore MD 21287

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: [signature] G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMND ITM#19B PR. F.H. G802 12-4-01 JAB

Certificate of Death

Reg. No. 2001 38624

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cleadia C. Smith

2. Date of Death Month Day Year: DECEMBER 1, 2001

3. Time of Death: 4:30A M

4a. Facility Name (If not institution, give street and number): MARYLAND GENERAL HOSPITAL

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 217-30-3080

6. Sex: 1☐M 2☑F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 6-4-1910

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☑Yes 2☐No

10e. Street and Number: 3915 Callaway Ave.

10f. Zip Code: 21215

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☑Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse

16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): James Costes

18. Mother's Name (First, Middle, Maiden Surname): Julia Chase

19a. Informant's Name/Ralationship (Type, Print): Edward L. Smith/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4501 Spring Ave HALTHORPE MD. ~~Balto MD~~ 21227

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Thomas Church Cemetery

Date: 12-5-01

20c. Location - City or Town, State: Balto. MD

21. Signature of Funeral Service Licensee: Linda L Mason

22. Name and Address of Facility: Vaughn C Greene Funeral Services 5151 Balto. Natl Pike 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Batwaen Onset and Death

Immediata Causa (Final disaasa or condition resulting in death): a. ASPIRATION PNEUMONIA

Sequentially list conditions, if any, laading to immediate causa. Enter Underlying Cause (Disaase or injury that initiated avents resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequance of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcoma of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at tima of death 5☐Other (specify) 9☐Unknown

23d. Data of dalivary Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

23e. Did tobacco use contribute to the cause of daath? 1☐Yas 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐Yas 2☐No

25. Was case rafarred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicida 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurrad at the time, date and placa, and dua to tha cause(s) and manner as statad. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: Richard C. Camacho, M.D.

29c. License number: P15696

29d. Data signed (Month, Day, Year): December 1, 2001

30. Name and address of person who comptated causa of daath (Item 23a) (Typa, Print): RICHARD C A MACHO C/O MARYLAND GENERAL HOSPITAL

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38625

STROMBERG, PATRICIA

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PATRICIA STROMBERG
2. Date of Death Month: 11 Day: 28 Year: 2001
3. Time of Death: 10:30 P
4a. Facility Name (If not institution, give street and number): Longview Nursing Home
4b. City, Town, or Location of Death: Manchester
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 218-66-0727
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 56 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 4/ 1945
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: MD
10b. County: Baltimore
10c. City, Town or Location: Owings Mills
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4639 Kings Mills Way
10f. Zip Code: 21117
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Teacher
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Lawrence Hellman
18. Mother's Name (First, Middle, Maiden Surname): Marie E. Witzke

19a. Informant's Name/Relationship (Type, Print): Marie Hellman-mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3800-3 C Sunnyfield Court, Hampstead, Md. 21074

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery
Date: 12/03/2001
20c. Location - City or Town, State: Woodlawn, Md.

21. Signature of Funeral Service Licensee: [signature] Schau
22. Name and Address of Facility: Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue, Catonsville, Md. 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. END STAGE HUNTINGTONS DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D28595
29d. Date signed (Month, Day, Year): 11/28/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 7220 Park Heights Ave, Balto MD 21208, TASNEEM LAKHANI

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38626

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
GLADYS	L.	SANDERS	DEC 01 2001	8:15 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6741 EDWARD AVE BALT 21244	Woodlawn	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Yeer)	9. Birthplace (State or Foreign Country)
218-16-2223	1☐M 2☒F	93 Yrs.			08/30/1908	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Woodlawn	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6741 Edward Avenue	21244	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Clerk	Woolworth Dept.Store

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Edward Saunders	Caroline Wolfe

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rita T. Sanders/Daughter-In-Law	6741 Edward Ave. Baltimore, MD 21244

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removet from State 4☐Donation 5☐Other (Specify)	Lorraine Park Cemetery	12/04/2001	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Bernard Dalsheim	Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CHRONIC RENAL FAILURE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

HYPOTHYROIDISM

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No 3☐Probably 4☐Unknown	1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
Jacob M Levine MD	D48189	DEC 03 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACOB M LEVINE MD 516 N Rolling RD CATONSVILLE MD 21228

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	Donna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38627

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RONALD SCOTT
2. Date of Death (Month, Day, Year): NOVEMBER 29 2001
3. Time of Death: 12:55 AM
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-14-1981
6. Sex: 1 [X] M 2 [ ] F
7. Age (If yrs. lest birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3-4-1925
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Insida City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2211 W.ROGERS APT W132
10f. Zip Code: 21209
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yas 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): -12- | College (1-4or 5+): -2-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR
18b. Kind of Business/Industry: POSTAL

17. Father's Name (First, Middle, Last): UNKNOWN
18. Mother's Nama (First, Middle, Maiden Surname): MARY S. POOLE

19a. Informant's Name/Ralationship (Type, Print): CANDACE SIMMS(DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3511 CEDARDALE RD. BALTIMORE, MARYLAND 21215

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) ENTOMBMENT
20b. Place of Disposition (Name of cemetery, crematory or other piece): ARBUTUS MEMORIAL PARK
Date: 12-8-2001
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Joath J. Hubner
22. Name and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

Approximata Intarval Batween Onsat and Death

Immediate Cause (Final disease or condition resulting in death): a. HEMORRHAGIC STROKE — 2 DAYS

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dua to (or as a consequence of):

c. Due to (or as a consequance of):

d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal daath 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of daath 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: MYOCARDIAL INFARCTION, CONGESTIVE HEART FAILURE

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Ware autopsy findings availabla prior to complation of ceusa of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Othar: 4 [ ] Nursing Home 5 [ ] Rasidance 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be datarmined
28a. Date of Injury (Month, Day Yaar)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Dascribe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowladga, daath occurrad at the time, data and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceusa(s) and manner stated.
29b. Signature and title of certifier: H. Christopher Lawson
29c. Licensa number: RES-000
29d. Date signed (Month, Day, Year): NOVEMBER 29 2001

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print): H. CHRISTOPHER LAWSON, MD 600 N. WOLFE ST., BALTIMORE, MD 21287

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signatura: Jennie D Jones

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #6 PER FH G802 12/04/01 JH

Certificate of Death

Reg. No. 2001 38628

Patient Known as Smeyne, Henry

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
HENRY	SMEYNE	November 30 2001	11:47 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sinai Hospital of Baltimore	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-10-5937	1 M 2 F	93 Yrs.			DEC. 9, 1907	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	OWINGS MILLS	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5000 HOLLINGTON DRIVE #102	21117	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes X No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		MANUFACTURER	AUTOMOTIVE

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
MOSES	SMEYNE	ANNIE	LEVIN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117
HARRIET SMEYNE / WIFE	5000 HOLLINGTON DRIVE #102 - OWINGS MILLS, MD

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	BETH EL MEMORIAL PK	12/3/2001	RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: ▶ Edward C. Rusnak

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration pneumonia

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Congestive heart failure

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnent in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnent at time of death 5 Other (specify) 9 Unknown

23d. Data of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of causa of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No

28. Place of Death (Check only one)

Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	RES-000	November 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Niccolo D. Della Penna, MD Sinai Hospital of Baltimore

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	

To be completed by the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38629

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Sosnow
2. Date of Death — Month: November; Day: 29; Year: 2001
3. Time of Death: 5:40 AM
4a. Facility Name (If not institution, give street and number): Veterans Affairs Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 170-20-3168
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR.4,1925
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7846 AMERICANA CIRCLE
10f. Zip Code: 21060
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALES
16b. Kind of Business/Industry: INDUSTRIAL SUPPLIES

17. Father's Name (First, Middle, Last): MORRIS SOSNOW
18. Mother's Name (First, Middle, Maiden Surname): IDA COHEN

19a. Informant's Name/Relationship (Type, Print): DEBRA ZUBRIS / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17 GOODWIN PARKWAY - SEWELL, NJ 08080

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD VETERANS CEMETERY
Date: 12/3/01
20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: Edward C. Rund
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. urosepsis — 2 weeks
Due to (or as a consequence of):
b. infected hip arthroplasty — 6 weeks
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

pseudomembranous colitis

hypoxic brain injury

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rose Chasm M.D.
29c. License number: AV4176425 13665
29d. Date signed (Month, Day, Year): November 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rose Chasm Baltimore VAMC 10 Norm. Greene Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38630

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Margaret Snyder
2. Data of Death (Month, Day, Year): December 1, 2001
3. Time of Death: 22:07 M
4a. Facility Name (If not institution, give street and number): Saint Agnes Hospital
4b. City, Town, or Location of Death: Baltimore Maryland
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-07-9379
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 90 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): April 1, 1911
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 4025 Wilkens Avenue
10f. Zip Code: 21229
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10
College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Patrick Brogan
18. Mother's Name (First, Middle, Maiden Surname): Mary Bourke

19a. Informant's Name/Relationship (Type, Print): Linda J. Snyder / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4025 Wilkens Avenue, Baltimore Maryland 21230

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cematary, crematory or othar place): New Cathedral Cemetery Date: December 5, 2001
20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.
22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failura. List only ona cause on each lina.

Immediate Cause (Final disease or condition resulting in death):
a. Coronary Arteriosclerotic Vascular Disease — Approximate Interval Between Onset and Daath: Unk.

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcoma of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at tima of deeth 5☐Othar (specify) 9☐Unknown
23d. Date of dalivary: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.: Hypertension

23a. Did tobacco usa contributa to the causa of death? 1☐Yas 2☐No 3☐Probably 4☒Unknown
24a. Was an autopsy performed? 1☐Yas 2☒No
24b. Wara autopsy findings availabla prior to completion of causa of death? 1☐Yas 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No
28. Place of Daath (Check only one): Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA; Othar: 4☐Nursing Homa 5☐Rasidenca 6☐Othar (Specify)
27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐Yas 2☐No
28d. Dascribe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at tha time, data and place, and dua to tha cause(s) and mannar as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at tha fima, data and placa, and dua to the causa(s) and manner stated.
29b. Signature and title of certifier: Scott Bergeson, MD
29c. License number: D0055849
29d. Data signad (Month, Day, Year): December 1, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scott Bergeson, M.D., Saint Agnes Hospital, 900 Caton Avenue Baltimore Maryland 21229

State Registrar

31. Data filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: Jenna B Yates

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked othar than "natural", or Items 23a or 28e-f show any injury or other traumatic avant, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Medical Certification;

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38631

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Grace Westervelt Tausendschoen

2. Date of Death: Month Nov, Day 26, Year 2001

3. Time of Death: 5:00 p.m.

4a. Facility Name *(If not institution, give street and number)*: Renaissance Gardens

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-28-0540

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth *(Month, Day, Year)*: Dec 9 1914

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 709 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teletype Operator

16b. Kind of Business/Industry: Railroad

17. Father's Name *(First, Middle, Last)*: Andrew Westervelt

18. Mother's Name *(First, Middle, Maiden Surname)*: Grace Strange

19a. Informant's Name/Relationship *(Type, Print)*: Grace Howard / daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 442 Fletcher Drive, Smyrna, Delaware 19977

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lorraine Park Cemetery

Date: 11/30/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Ann Y. Zink

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive heart failure — days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atherosclerotic coronary artery disease — Years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Myla M Carpenter MD

29c. License number: D 30989

29d. Date signed *(Month, Day, Year)*: November 27 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Myla M Carpenter MD 711 Maiden Choice Ln Catonsville MD

State Registrar

31. Date Filed *(Month, Day, Year)*: DEC 04 2001

32. Registrar's Signature: Jeanne B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38632

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wilfrieda E. Thorpe
2. Date of Death (Month, Day, Year): November 30, 2001
3. Time of Death: 9:45 am
4a. Facility Name (If not institution, give street and number): 6602 Woods Parkway
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-60-3563
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 9, 1951
9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6602 Woods Parkway
10f. Zip Code: 21222
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Rental Agent
16b. Kind of Business/Industry: Apartment Complex

17. Father's Name (First, Middle, Last): Wilfred Herritt
18. Mother's Name (First, Middle, Maiden Surname): Carrie Beal

19a. Informant's Name/Relationship (Type, Print): Robert Thorpe Sr. Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6602 Woods Parkway, Dundalk, Md. 21222

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory
Date: Dec. 4, 2001
20c. Location - City or Town, State: Baltimore City

21. Signature of Funeral Service Licensee: ▶ Anthony C. Connelly
22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Solliers POint Road, Dundalk, Md. 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. probable acute pulmonary embolism — 2 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
s/p resection for colon cancer, receiving Adjuvant chemotherapy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M. Pinteo Staff Physician
29c. License number: 019714
29d. Date signed (Month, Day, Year): 12/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL PINTEO, JHBMC 4940 EASTERN AVE, BALTIMORE MD 21224

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: ▶ Deputy B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed/filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#7 perFHG802 12/04/01 EW

Certificate of Death

Reg. No. 2001 38633

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DORTRIE TAYLOR

2. Date of Death (Month, Day, Year): NOVEMBER 29, 2001

3. Time of Death: 6:45am

4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-64-8862

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 46 ~~47~~ Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 5-1-1955

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5006 FRANKFORT AVE.

10f. Zip Code: 21206

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): -12- | College (1-4or 5+): -0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERK

16b. Kind of Business/Industry: WATER?WASTE

17. Father's Name (First, Middle, Last): KENNETH TAYLOR

18. Mother's Name (First, Middle, Maiden Surname): PHOEBE STOKES

19a. Informant's Name/Relationship (Type, Print): SANDRA REINHARDT(SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1117 WICKLOW RD. BALTIMORE, MARYLAND 21229

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY

Date: 12-3-2001

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Joseph D. Hurn

22. Name and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ANOXIC ENCEPHALOPATHY — 1 WEEK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES, HYPERTENSION, END STAGE RENAL DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: B Ayi, MD

29c. License number: P13451

29d. Date signed (Month, Day, Year): NOVEMBER 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BERTHA AYI GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD. BALTO., MD. 21239

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: Deputy D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

N

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38634

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Mildred A. Venson	December 1, 2001	8:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
11509 Chesley Court	Mitchellville	Prince George

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-46-1563	1☐M 2☒F	81 Yrs.			Feb. 19, 1920	Georgia

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George	Mitchellville	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11509 Chesley Court	20721	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	Registered Nurse	Nursing Home
	4		

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Dan Joyce	Emma Miller

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joyce Yates/Daughter	11509 Chesley Ct., Mitchellville, MD 20721

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Fort Lincoln Cemetery	12-05-2001	Brentwood, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Bizarre Coma	14 hrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent et time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	MD 3 d0	December 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Allen M. Mondzac 2150 Pennsylvania Ave.,NW Washington, D.C. 20037

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

01-6749-510
mnmr
WILLIAM WATTS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38635

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Milton Watts
2. Date of Death (Month, Day, Year): NOVEMBER 28, 2001
3. Time of Death: 1632 PM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-40-6741
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 60 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05 06 41
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 740 Popular Grove Street
10f. Zip Code: 21216
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [XX] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Barber
16b. Kind of Business/Industry: Heavy's Barber Shop

17. Father's Name (First, Middle, Last): Milton Watts
18. Mother's Name (First, Middle, Maiden Surname): Viola Garner

19a. Informent's Name/Relationship (Type, Print): Sharon Watts-Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 727 Roundview Road, Baltimore Md 21225

20a. Method of Disposition: 1 [ ] Burial 2 [XX] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 12/6/01
20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? limited 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): NOVEMBER 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE MILLING
111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38636

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Samuel E. Woodfolk

2. Date of Death: Month November Day 11 Year 2001

3. Time of Death: 10:10PM

4a. Facility Name (If not institution, give street and number): 531 Randolph Road

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-50-0711

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 19, 1938

9. Birthplace (State or Foreign Country): Washington, DC.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 531 Randolph Rd.

10f. Zip Code: 20904

10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Master Carver

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Anthony Woodfolk

18. Mother's Name (First, Middle, Maiden Surname): Louise Harris

19a. Informant's Name/Relationship (Type, Print): Kenneth Woodfolk/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10107 Bending Brook Way Upper Marlboro, MD. 20772

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Washington National Cem. Date: 11/17/01

20c. Location - City or Town, State: Suitland, MD.

21. Signature of Funeral Service Licensee: ▶ Ava D. Mitchell

22. Name and Address of Facility: Pope Funeral Homes, 5538 Marlboro Pike Forestville, MD. 20747

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Chronic Renal Failure

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ James M. Salander

29c. License number: D39064

29d. Date signed (Month, Day, Year): 12/4/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James M. Salander, 11119 Rockville Pk. #204 Rockville, MD. 20852

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38637

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Geraldine Washington

2. Date of Death: Month: Novemba Day: 29 Year: 2001

3. Time of Death: 7:10 PM

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-20-1427

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 6-21-16

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 901 N. Kenwood Ave

10f. Zip Code: 21205

10g. Citizen of What Country? U.S.A

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11th

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Ward - Clerk

16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Myrtle Johnson

19a. Informant's Name/Relationship (Type, Print): Ivory Randolph

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 904 N. Kenwood Ave Balto MD 2120-

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Gettysburg Veterans Cem

Date: 12-7-01

20c. Location - City or Town, State: PA

21. Signature of Funeral Service Licensee: Patricia Betts

22. Name and Address of Facility: Betts Funeral Home 1129 N. Caroline St Balto MD 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Mitral Regurgitation — Approximate Interval: 3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. End Stage Renal Disease — Approximate Interval: one month

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Abdominal Aortic Aneurysm

Gastrointestinal bleeding

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James O. Mudd MD

29c. License number: RES-000

29d. Date signed (Month, Day, Year): November 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James O. Mudd The Johns Hopkins Hospital 600 N Wolfe St. Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: Barbara D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38638

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Glenn E. Walborn

2. Date of Death (Month, Day, Year): December 3, 2001

3. Time of Death: 1:10 pm

4a. Facility Name (If not institution, give street and number): Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 162-07-8571

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 19, 1915

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decadant

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 719 Maiden Choice Lane BR 212

10f. Zip Code: 21228

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Business/Industry: Department Store

17. Father's Name (First, Middle, Last): Homer Walborn

18. Mother's Name (First, Middle, Maiden Surname): Rose Baker

19a. Informant's Name/Relationship (Type, Print): Violet E. Walborn - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 719 Maiden Choice Lane BR 212, Catonsville, MD 21228

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory, Inc. | Date: 12/5/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cholangiocarcinoma — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D 51051

29d. Date signed (Month, Day, Year): December 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andres Salazar 711 Maiden Choice Lane, Catonsville, Maryland 21228

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Name: Glenn Walborn

& 20

State Registrar

31. Date filed (Month, Day, Year): DEC 04 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38639

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
GLENDA L. WALKER	NOV. 30 2001	10:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Howard County General Hospital	Columbia	Howard

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
040-40-0948	1 ☐ M 2 ☒ F	55 Yrs.					AUG 18, 1946	Connecticut

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Howard	Columbia	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10405 Hickory Ridge Road Apt. C	21044	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Receptionist	Office

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ralph Sheppard	Irma Lee Hill

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Leah Beth Walker/Daughter	10405 Hickory Ridge Rd. #C Columbia, MD 21044

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metro Crematory Inc.	12-3-01	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Thomas Gregori	Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Intracranial Hemorrhage — Approximate Interval: 1 day.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Data of delivery
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Brain Cancer

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Abeda Ali Khan M.D.	D43323	NOV. 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABEDA ALI, KHAN 10794 Hickory Ridge Road, Columbia MD 21044

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 2001	▶ Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar Amended item#20b perFH FCHD,KS

Reg. No. 2001 38640

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Edward BOWIE
2. Date of Death (Month, Day, Year): NOV. 14 2001
3. Time of Death: 5 P M
4a. Facility Name (If not institution, give street and number): MONTGOMERY General Hosp.
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 215-14-1819
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 29, 1922
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: PRINCE GEORGE
10c. City, Town or Location: Landover
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 6802 Hawthorne St.
10f. Zip Code: 20785
10g. Citizen of What Country? U. S. A.

11. Marital Status: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4or 5+):
16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): self-employed
18b. Kind of Business/Industry: Television Repair

17. Father's Name (First, Middle, Last): Charles H. Bowie
18. Mother's Name (First, Middle, Meiden Surname): Frances Johnson

19a. Informant's Name/Relationship (Type, Print): (SISTER) Bernadine Helms
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 470 Carrolton Dr. Frederick Md 21701

20a. Method of Disposition: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Metro Crematory
Date: 11-23-2001
20c. Location - City or Town, Stete: Balt. Md.

21. Signature of Funeral Service Licensee: ▶ Mary L. Rollins
22. Name and Address of Facility: Gary L. Rollins Funeral Home 110 West South St. Frederick Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): ASPIRATION PNEUMONIA — 2 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as e consequence of): DEMENTIA — 2YEARS
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetel deeth 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Deta of delivary: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

RENAL INSUFFICENCY
DEIABITUS ULCER

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
24e. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy tindings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
28. Place of Death (Check only one): Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner es stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to tha cause(s) and menner stated.

29b. Signature and title of certifier: ▶ obj. mgr. MD
29c. License number: D23630
29d. Dete signed (Month, Day, Yaar): November 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANK J. MAYO, MD 16220 FREDERICK RD #213 GAITHERSBURG, MD 20877

State Registrar

31. Date filed (Month, Day, Year): NOV 2 0 2001
32. Registrar's Signature: ▶ Jennie B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38641

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Myrtle	Mamie	Berner	November 17, 2001	4:30 am M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Edenton Retirement Community	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
110-12-5274	1☐M 2☒F	92 Yrs.			Sep 25, 1909	New York

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5901 Genesis Lane	21703	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Inventory Clerk	Telecommunications

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John C Berner	Elsie C Harrer

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Mildred O'Neal/Sister	6861 Snowberry Court, Frederick, Maryland 21703

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Cypress Hills Cemetery	Nov 21, 2001	Brooklyn, New York

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kathlynn Roberson M00706	Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerotic Coronary Vascular Disease	Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Assisted Living

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D47611	November 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neil Waravdekar, M.D., 1475 Taney Avenue, Suite 201, Frederick, Maryland 21702-5127

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	▶ [signature] G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38642

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lawrence Edward Brian

2. Date of Death (Month, Day, Year): October 31, 2001

3. Time of Death: 0200

4a. Facility Name (If not institution, give street and number): 3493 Linchester Road

4b. City, Town, or Location of Death: Preston

4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 213-44-1008

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 9, 1945

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Caroline

10c. City, Town or Location: Preston

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3493 Linchester Road

10f. Zip Code: 21655

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: '63-66

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer

16b. Kind of Business/Industry: Poultry

17. Father's Name (First, Middle, Last): Carlton E. Brian

18. Mother's Name (First, Middle, Maiden Surname): Mary Frances Dickerson

19a. Informant's Name/Relationship (Type, Print): Karen C. Brian/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3493 Linchester Rd., Preston, MD 21655

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Old Sch. Baptist Cem.

Date: 11/4/01

20c. Location - City or Town, State: Laurel, Delaware

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Framptom-Hawkins-Eskow Funeral Home, PA
PO Box 43, Federalsburg, MD 21632

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Pancreatic Cancer — 5-6 mos

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Lymphedema, Hypercoagulation DVT

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: 44752

29d. Date signed (Month, Day, Year): Nov 2nd 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John A. Appiotti DO 3304 Haynie Drive Federalsburg MD 21632

State Registrar

31. Date filed (Month, Day, Year): NOV 0 2 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38643

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Arnold Andreas Brooks

2. Date of Death Month Day Year: October 30 2001

3. Time of Death: 7:00 pm

4a. Facility Name *(If not institution, give street and number)*: Chesapeake Woods

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 218-50-0905

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 14,1948

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Dorchester

10c. City, Town or Location: Woolford

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1609 Heliport Road

10f. Zip Code: 21677

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Painter

16b. Kind of Business/Industry: Residential/Ind.

17. Father's Neme *(First, Middle, Last)*: Andreas Arnold Brooks

18. Mother's Name *(First, Middle, Maiden Surneme)*: Marjorie Vivian Bramble

19a. Informant's Name/Relationship *(Type, Print)*: A.Arnold Brooks/Father

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 507 Burton St., Cambridge, MD 21613

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Neme of cemetery, cremetory or other piece)*: Old Trinity Cemetery

Date: 11/1/01

20c. Location - City or Town, State: Church Creek, MD

21. Signature of Funeral Service Licensee: ▶ A Boale

22. Name and Address of Facility: Framptom-Hawkins-Eskow Funeral Home,PA 216 N. Main St. Federalsburg, MD 21632

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. AIDS — 6 yrs.

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Lymphoma

Due to (or es a consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: ▶ MD

29c. License number: D0057290

29d. Date signed *(Month, Day, Year)*: 10/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martin L. Garcia-Bunuel, MD 503 Muir St. Cambridge, MD 21613

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 0 2 2001

32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#8 perFHG802 12/04/01 EW

Certificate of Death

Reg. No. 2001 38644

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leona G. Bailey
2. Date of Death: Month Nov. Day 18, Year 2001
3. Time of Death: 11:00 AM
4a. Facility Name (If not institution, give street and number): 1501 Warehime Rd.
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 220-01-1498
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr. 15, ~~2001~~ 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Florida
10b. County: Palm Beach
10c. City, Town or Location: Boynton Beach
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4404 Knight Rd.
10f. Zip Code: 33436
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator
16b. Kind of Business/Industry: Bakery

17. Father's Name (First, Middle, Last): Levi Gamber
18. Mother's Name (First, Middle, Maiden Surname): Margie Mancha

19a. Informant's Name/Relationship (Type, Print): David Bailey/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1501 Warehime Rd. Westminster, MD 21158

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremations, Inc.
Date: 11/19 2001
20c. Location - City or Town, State: Hampstead, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Pritts Funeral Home & Chapel, P.A. 412 Washington Rd., Westminster, MD 21157

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Colon Cancer - Metastatic — 2yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Sons Home

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] John W. Middleton
29c. License number: D25443
29d. Date signed (Month, Day, Year): 11/19/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W. Middleton 688 Poole Road, Westminster, Md 21157

State Registrar

31. Date filed (Month, Day, Year): NOV 19 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CARROLL #8

CEW 8

01-6126-033
crn
Kelly L. Byrd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar: Amend item #26 per Verbal G802 12/04/01 EW

Certificate of Death

Reg. No. 2001 38645

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month Day Yaar	3. Time of Death
Kelly Lamont Byrd	October 30, 2001	3:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Route 50 & Columbia Park Drive	Cheverly	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Yaar)	9. Birthplace (State or Foreign Country)
579-04-3637	1☒M 2☐F	36 Yrs.			6-5-1965	Washington, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	Largo	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
257 Campus Way South #31	20774	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Mechanic	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Norman Byrd	Sandra Killebrew

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Norman Byrd/Father	5615 Sheriff Rd. Capitol Heights, MD 20743

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Washington Nat'l	11/02/2001	Suitland, MD

21. Signatura of Funeral Servica Licensee	22. Name and Address of Facility
▶ K.E.W.	J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Neck Injuries

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Dua to (or as a consequence of):
c. Dua to (or as a consequence of):
d. Dua to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Data of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to tha cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☑Yes 2☐No	1☑Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residenca 8☒Othar (Specify) Scene

27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	10/30/01	2:40 AM	1☐Yes 2☑No	Occupant of Motor Vehicle Impacts Fixed objects

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify): Street

28f. Location (Street and Number or Rural Route Number, City or Town, State): Rt. 50 + Columbia Park Drive; Prince George's County, Md.

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J Pestaner MD	O.C.M.E.	October 30, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signatura
NOV 05 2001	

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

CR
Rg. # 26
6

DHMH 17 Rev 1/2001

ORIGINAL

NOV 05 2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#23a perPHYG802 12/04/01 EW

Certificate of Death

Reg. No. 2001 38646

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Karen Sue Bush	October 25, 2001	9:30 p.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Garrett County Memorial Hospital	Oakland	Garrett

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
235-72-8247	1☐M 2☒F	54 Yrs.			Mar. 6, 1947	West Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
WV	Grant	Mount Storm	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
HC 76, Box 641	26739	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 th		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Roy W. Rogers	Della A. Keener

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Donald R. Bush, Sr./husband	HC 76, Box 641, Mount Storm, WV 26739

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Odd Fellows Cem.	Oct 30, 2001	Cowen, WV

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ D Lee Newman	Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Diabetic Nephropathy ~~with acute and chronic~~	2 years
Due to (or as a consequence of):	~~Renal Failure~~ Nephrotic Syndrome	2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):	ACUTE AND CHRONIC RENAL FAILURE	2 Years
c.		
Due to (or as a consequence of):		
d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease, Hypercholesterolemia, Diabetes Mellitus, Type II, uncontrolled, Hypertension, Coronary Artery Disease with coronary artery bypass grafting

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one) Hospital:	Other:
1☐Yes 2☒No	1☒Inpatient 2☐ER/Outpatient 3☐DOA	4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Margaret A Kaiser	D26650	10/26/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Margaret A Kaiser MD 13079 Garrett HIghway Oakland, MD 21550

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 29 2001	▶ Brenda D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

GARRETT 0038?

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar: Amend Item#26 per VERBALG802 12/04/01 EW

Certificate of Death

Reg. No. 2001 38647

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month	Day	Year	3. Time of Death
Dorothy	Maxine	BROWN	Nov.	8,	2001	10:20 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Daath	4c. County of Deeth
67 Monte Vista Road	Oakland	Garrett

Funeral Director

5. Social Security Number	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplece (State or Foreign Country)
219-14-5028	1☐M 2☒F	75 Yrs.					Mar. 23, 1926	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Garrett	Oakland	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
201 Mason St., Apt. 19	21550	USA

11. Maritel Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yeer or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th		Machine Operator	Lens Manufacturing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
Erlbeck ----- MOSES	Charlotte ----- FAZENBAKER

19a. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Patty J. Guthrie/Daughter	67 Monte Vista Road, Oakland, Md. 21550

20e. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other place)	Data	20c. Location - City or Town, Stata
1☒Burial 2☐Cremation 3☐Removal from Stata 4☐Donation 5☐Other (Specify)	Oak Hill Cemetery	11/10/01	Lonaconing, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Bradley A. Stewart	Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Daath
Immediate Cause (Finel disease or condition resulting in death)	a. Lung Carcinoma	Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last	Due to (or as e consequence of): b.	
	Due to (or as e consequence of): c.	
	Due to (or as e consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal daath 3☐Ectopic pregnancy 4☐Pregnant at lima of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to daath but not resulting in tha underlying causa given in Part I.

23e. Did tobacco use contributa to tha cause of daath?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) Daughter's Residence

27. Menner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2☐**Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, deta and place, end due to the causa(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Yeer)
▶ P. Daniel Miller	H26154	11/9/2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)
P. Daniel Miller D.O. 69 Wolfe Acres Drive, Oakland, Md. 21550

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
NOV - 9 2001	▶ Jenna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

GARRETT # YA-1015-26

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38648

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Percival G. Coon

2. Date of Death Month Day Year: November 14, 2001

3. Time of Death: 6:55 P.M

4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 027-09-7933

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 7, 1912

9. Birthplace *(State or Foreign Country)*: Massachusetts

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Mount Airy

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 705 Midway Avenue

10f. Zip Code: 21771

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Accountant

16b. Kind of Business/Industry: Private Industry

17. Father's Name *(First, Middle, Last)*: Allison Coon

18. Mother's Name *(First, Middle, Maiden Surname)*: Maude Lutz

19a. Informant's Name/Relationship *(Type, Print)*: Elizabeth M. Coon - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 208 Dill Avenue, Frederick, Maryland 21701

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Matropolitan Crematorium

Date: 11/17/2001

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Robert L. Williams

22. Name and Address of Facility: Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Myocardial infarction

Approximate Interval Between Onset and Death: 1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fatal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other *(specify)* 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Renal insufficiency
Anemia

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D00055518

29d. Date signed *(Month, Day, Year)*: 11/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHEN TUNG 310 W 9th Frederick 21701

State Registrar

31. Date filed *(Month, Day, Yaar)*: NOV 19 2001

32. Registrar's Signature: Geneva G Sparks

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38649

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Dey / Year	3. Time of Death
Herman	Leroy	Carter, Jr.	November 17 2001	10:40 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4102-A Ijamsville Road	Ijamsville	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-34-2711	1☒M 2☐F	64 Yrs.			April 28, 1937	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Ijamsville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
4102-A Ijamsville Road	21754	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐Never Married 2☒Merried 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
11		Security Sergeant	Security

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
Herman Carter	Marcella Snowden

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Sondra Carter / Wife	4102-A Ijamsville Road Ijamsville, Maryland 21754

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Buriel 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)	Ebenezer UMC Cemetery	November 23, 2001	Ijamsville, Maryland

21. Signeture of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Dehyrdration	2 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	Due to (or as a consequence of): b. Prostate Cancer	years
	Due to (or es a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Data of delivery Month / Dey / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent et time ot death 5☐Other (specify) _____ 9☐Unknown	

Part II. Othar significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings availeble prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined		M	1☐Yes 2☐No	
	26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at tha time, date end place, end due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature], MD	D41866	November 19, 2001

30. Neme and address ot person who completed cause of deeth (Item 23a) (Type, Print)
Kanan Hudhud, MD 801 Tollhouse Avenue, F Frederick, MD 21701

10

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38650

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Lloyd Franklin Cooper, Sr.	November 19, 2001	11:20 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Beverly Health Care of Frederick	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-32-6915	1 X M 2 ☐ F	68 Yrs.			May 14, 1933	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Jefferson	1 ☐ Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
2746 Lander Road	21755	U.S.A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Dairy Farmer	Farming

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Richard David Cooper	Nellie Harper

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Ethel Cooper, wife	2746 Lander Road, Jefferson, Maryland 21755

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
X 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)	St. Pauls Cemetery,	Nov. 23, 2001	Point of Rocks, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Richard E. Stof M00255	Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Finat disease or condition resulting in death)	a. PANCREATIC CARCINOMA	6 MOS
Sequentially tist conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that intieted events resulting in death) Last	b. Due to (or as e consequence of):	
	c. Due to (or as e consequence of):	
	d. Due to (or as e consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant et time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of deeth?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
1 ☐ Yes 2 X No 3 ☐ Probebly 4 ☐ Unknown	1 ☐ Yes 2 X No	1 ☐ Yes 2 ☐ No

25. Was cese referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Deth	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1 X Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner es stated.
2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ W. Allgair MD	D16675	November 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wayne Allgaier, M.D., 610 Ninth Ave., Brunswick, Maryland 21716

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	▶ Barbara G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38651

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
GLADYS	CROSS	NOVEMBER 20, 2001	12:20 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
567-34-2364	1☐M 2☒F	84 Yrs.			Dec. 5, 1916	Oklahoma

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Frederick	Frederick	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7810 Spout Springs Road	21702	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	school teacher	school board

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Lewis Clark Brooks	Claudine Louphelia Love

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Larry Cross/Son	3088 Lockwood Drive Middletown, MD 21769

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Parklawn Cemetery	Nov. 24, 2001	Rockville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jacqueline Vrla	Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Atrial fibrilation	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Congested heart failure.	
	Due to (or as a consequence of): c. Pneumonia.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary arterial disease

Dementia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Hague MD	D0054636	11/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Syed Hague 700 Montclaire Ave. FREDERICK MD. 21701

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 21 2001	▶ Penny G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Item 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38652

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSELLE CURTIS
2. Date of Death: Month October Day 25 Year 2001
3. Time of Death: 04:29 AM
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE City

Funeral Director

5. Social Security Number: 213-24-2469
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 29, 1925
9. Birthplace (State or Foreign Country): MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Caroline
10c. City, Town or Location: Federalsburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 204 Brooklyn Avenue
10f. Zip Code: 21632
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Processor
16b. Kind of Business/Industry: Food

17. Father's Name (First, Middle, Last): Lacey Pinckens
18. Mother's Name (First, Middle, Maiden Surname): Zilda Lucretia Johnson

19a. Informant's Name/Relationship (Type, Print): Naomi Flowers/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 204 Brooklyn Ave., Federalsburg, MD 21632

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Federal Hill Cem.
Date: 10/30/01
20c. Location - City or Town, State: Federalsburg, MD

21. Signature of Funeral Service Licensee: ▶ Michael A. Eskow
22. Name and Address of Facility: Framptom-Hawkins-Eskow Funeral Home, PA Federalsburg, MD 21632

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PULMONARY EMBOLUS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Data of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
GASTROINTESTINAL BLEEDING
ATRIAL FIBRILLATION

23e. Did tobacco use contribute to tha cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and dua to the causa(s) and manner stated.

29b. Signature and title of certifier: ▶ Chirag Chaudhari MD
29c. License number: AU41764350137 42
29d. Date signed (Month, Day, Year): 10/25/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHIRAG CHAUDHARI, 22 S. GREENE ST., BALTIMORE, MD 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 3 1 2001
32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

VOID

CERTIFICATE ##

01-38653

SEE

CERTIFICATE ##

01-41153

01-38623

01-41123

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38654

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month Day Yaar	3. Tima of Death
Robert Emil Diaz	November 14, 2001	8:50 P M

4a. Facility Nama (If not institution, give street and number)	4b. City, Town, or Location of Daath	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Aga (In yrs. last birthday)	If Undar 1 Year Months	If Undar 1 Year Days	If Undar 24 Hrs. Hours	If Undar 24 Hrs. Min.	8. Date of Birth (Month, Day, Yaar)	9. Birthplace (State or Foraign Country)
217-44-7122	1☒M 2☐F	56 Yrs.					Sept. 24 1945	Puerto Rico

Usual Residence of Decedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Monrovia	1☐Yas 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizan of What Country?
11914 Wonder Court	21770	United States

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forcas?	13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.)	14. Race - Amarican Indian, Black, Whita, atc.
1☐Nevar Mamied 2☒Married 3☐Widowed 4☐Divorced	1☐Yaa 2☒No If Yes, Giva Year or Dates:	1☒Yes 2☐No Specify: Puerto Rican	Specify: White

15. Decedent's Education (Specify only highast grada completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+) 4	Wholesaler	Auto Business

17. Fathar's Nema (First, Middle, Last)	18. Mothar's Nama (First, Middle, Meiden Surname)
Roberto Diaz	Julia Vasquez Marra

19a. Informant's Neme/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)
Rayeann Diaz/ Wife	11914 Wonder Court, Monrovia, Maryland 21770

20a. Method of Disposition	20b. Place of Disposition (Nama of cematary, crematory or othar place)	Data	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Ramoval from Stata 4☐Donation 5☐Othar (Specify)	Metropolitan Crematorium	11/17/01	Alexandria, Virginia

21. Signature of Funaral Service Licensee	22. Nama and Addrass of Facility
Todd Wynne	Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter tha diseasa, or complications that caused the death. Do not antar the moda of dying, such as cardiac or respiratory errest, shock, or heart failura. List only ona cause on each lina.

		Approximate Intarval Betwaen Onset and Death
Immediate Cause (Final disease or condition resulting in daath)	a. PULMONARY EMBOLISM	2 HRS
Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disaasa or injury that initiated events resulting in daath) Last	Dua to (or as a consequenca of): b.	
	Dua to (or as a consequence of): c.	
	Dua to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in tha past 12 months?	23c. If yes, outcome of pregnancy	23d. Data of delivery Month Day Year
1☐Yas 2☐No 9☐Unknown	1☐Live birth 2☐Fetal daath 3☐Ectopic pregnancy 4☐Pregnant at lima of daath 5☐Other (specify) _____ 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I.

CORONARY ARTERY DISEASE,
PERITONEAL FIBROSIS

23e. Did tobacco use contributa to tha causa of daath? 1☐Yas 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Wera autopsy findings available prior to compiation of causa of death?
1☒Yas 2☐No	1☒Yas 2☐No

25. Was case retarred to medical examinar?	26. Placa of Daath (Chack only ona)	
1☐Yas 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Othar: 4☐Nursing Horna 5☐Residanca 6☐Othar (Specify)

27. Mannar of Death	28a. Data of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Pending investigation 6☐Could not be datarmined		M	1☐Yes 2☐No	

28a. Place of Injury - At horna, farm, straat, factory, offica building, atc. (Specify)	28f. Location (Street and Number or Rural Routa Numbar, City or Town, State)

29a. Cartifiar (Check only one) 1☒**Certifying Physician:** To tha best of my knowledga, death occurred at tha tima, date and placa, and dua to tha cause(s) and mannar as stated. 2☐**Medical Examinar:** On tha basis of examination and/or investigation, in my opinion, death occurred at tha tima, date and piece, and dua to the cause(s) and mannar slated.

29b. Signatura and title of certifier	29c. Licensa number	29d. Data signad (Month, Day, Year)
MD	D21936	11/16/01

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)
A. DONELSON MD 170 THOMAS JOHNSON DR SUITE 100 21702

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ok per Georgie faxed 11/19

State Registrar

31. Data filed (Month, Day, Yaar)	32. Registrar's Signatura
NOV 19 2001	Donna B Sparks

DHMH 17 Rav 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38655

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
Ellen	Elizabeth	Davis	November 17, 2001	6:45 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Northampton Manor Nursing Center	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-05-6538	1☐ M 2☒ F	83 Yrs.			Jan 13, 1918	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
200 East 16th Street	21701	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Clerk/Attendant	Drug Store

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Henry Shultz	Ada F Crist

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Cindy Hilland/Friend	11644 S.W. Egret Circle, Lake Suzy, FL 34269

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Mt Olivet Cemetery	Nov 21, 2001	Frederick, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kathryn Roberson MO0706	Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Lung disease

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonia

Due to (or as a consequence of):

c. Left ventricular hypertrophy

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Data ot delivery
1☐ Yes 2☑ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnent at time of death 5☐ Other (specify) 9☐ Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	26a. Date of Injury (Month, Day Year)	26b. Time of Injury	26c. Injury at Work?	26d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Haque MD.	D 0054636	11/19/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Syed W. Haque, 700 Montclaire Avenue, Frederick, Md. 21701

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	▶ Bonnie G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item #23a per PHYG802 12/04/01 EW

Certificate of Death

Reg. No. 2001 38656

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUTH HADDER DENNIS

2. Date of Death: Month 11/01 Day Year 2001

3. Time of Death: 8:30 A.M.

4a. Facility Name (If not institution, give street and number): 200 Broad Street

4b. City, Town, or Location of Death: Berlin

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 213-24-1877

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12/26/1927

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: Worcester

10c. City, Town or Location: Berlin

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 200 Broad Street

10f. Zip Code: 21811

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Handy Hadder

18. Mother's Name (First, Middle, Maiden Surname): Mary Kelly

19a. Informant's Name/Relationship (Type, Print): William Lee Dennis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 200 Broad Street Berlin, MD. 21811

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Sunset Memorial Park

Date: 11/5/01

20c. Location - City or Town, State: Berlin, MD.

21. Signature of Funeral Service Licensee: W. Fisk Burbage

22. Name and Address of Facility: Burbage Funeral Home 108 William Street Berlin, MD 21811

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. DECUBITI

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. STROKE

Due to (or as a consequence of):

c. ~~DM, HPN, AF~~ DIABETES MELLITUS

Due to (or as a consequence of):

d. ATRIAL FIBRILLATION

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Gonzalez, M.D.

29c. License number: D 25796

29d. Date signed (Month, Day, Year): 11-1-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LILAH E. GONZALEZ, M.D. 314 Franklin St. Berlin, MD 21811

State Registrar

31. Date filed (Month, Day, Year): NOV 05 2001

32. Registrar's Signature: Tamara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

incorrect #23a

E.T. 8

01-6086-011
B.K.S
TIMOTHY LEE EWING

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38657

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Timothy Lee Ewing	OCT. 26, 2001	2230 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SHORE HIGHWAY	DENTON	CAROLINE

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-94-7002	1[X] M 2[ ] F	23 Yrs.			Aug. 18, 1978	Delaware

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Caroline	Federalsburg	1[ ] Yes 2[X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
28331 Shore Highway	21632	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[X] Never Married 2[ ] Married 3[ ] Widowed 4[ ] Divorced	1[ ] Yes 2[X] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Landscaper	Landscaping

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Milton W. Ewing, Sr.	Shirley Warren Dardas

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Milton W. Ewing, Sr.	409 Railroad Ave., Federalsburg, MD 21632

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	Bloomery Cemetery	10/31/01	Federalsburg, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Michael F. Eskow	Framptom-Hawkins-Eskow Funeral Home, PA Federalsburg, MD 21632

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE INJURIES

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnent in the past 12 months? 1[ ] Yes 2[ ] No 9[ ] Unknown	23c. If yes, outcome of pregnancy 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnency 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1[ ] Yes 2[✓] No 3[ ] Probably 4[ ] Unknown

24a. Was an autopsy performed? 1[✓] Yes 2[ ] No	24b. Were autopsy findings available prior to completion of cause of death? 1[✓] Yes 2[ ] No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1[X] Yes 2[ ] No	26. Place of Death (Check only one) Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA Other: 4[ ] Nursing Home 5[ ] Residence 6[X] Other (Specify) AT SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[ ] Natural 2[✓] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined	10-26-01	2219 P M	1[ ] Yes 2[✓] No	PEDESTRIAN STRUCK BY TRUCK

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
ROADWAY	SHORE HWY DENTON CAROLINE CO MD

29a. Certifier (Check only one)
1[ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2[X] **Medical Examiner:** On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at tha time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Marlynn Mc Grath MD	O.C.M.E	OCT. 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARYANNE A. KOBER 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 31 2001	Penny G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38658

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clement James Gresock

2. Date of Death: Month November Day 16 Year 2001

3. Time of Death: 10:52 PM

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 300-24-5470

6. Sex: 1☐M 2☐F X

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 9, 1921

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Braddock Heights

10d. Inside City Limits: 1☐Yes 2☒No X

10e. Street and Number: 6743 Deer Spring Lane

10f. Zip Code: 21714

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐Never Married 2☒Married X 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2☐No If Yes, Give Year or Dates: 1939-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No XX Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): +5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clinical Psychologist

16b. Kind of Business/Industry: University

17. Father's Name (First, Middle, Last): Stephen Michael Gresock

18. Mother's Name (First, Middle, Maiden Surname): Mary Smelko

19a. Informant's Name/Relationship (Type, Print): Mrs. Marjorie L. Gresock, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6743 Deer Spring Lane, Braddock Heights, Md. 21714

20a. Method of Disposition: 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Olivet Cemetery

Date: Nov. 21, 2001

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: [signature] M00255

22. Name and Address of Facility: Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. GASTROINTESTINAL HEMORRHAGE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. GASTRIC VASCULAR ANOMALY

Due to (or as a consequence of):

c. RENAL FAILURE

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D 39846

29d. Date signed (Month, Day, Year): November 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sean E. Hunt, M.D., 310 West Ninth Street, Frederick, Maryland 21701

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

2D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38659

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Eulah Susanna Gouker	November 17, 2001	6:10 PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Citizens Nursing Home	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-20-2881	1 M 2 XX F	96 Yrs.			Nov. 16, 1905	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1 Yes 2 XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5826 Shookstown Road	21702	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married XX Widowed 4 Divorced	1 Yes 2 XX No If Yes, Give Year or Dates:	1 Yes 2 XX No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
William	Harris	Mattie	Wachter

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Carroll Plowman, grandson	5826 Shookstown Road, Frederick, Md. 21702

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Faith United Church Cemetery,	Nov. 20, 2001	Frederick, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Richard E. Graf M00255	Keeney and Basford PA Funeral Home 106 East Church Street, Frederick, Md. 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Hypertensive Cardiovascular Disease	3yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1 Yes 2 X No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No 3 Probably 4 Unknown	1 Yes 2 X No	1 Yes 2 X No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 X Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Robert L. Kaufmann	D-13971	November 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert L. Kaufmann, M.D., 300 West Ninth Street, Frederick, Md. 21701

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38660

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
Jane	Glover	November 18, 2001	12:48 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Tranquillity at Fredericktowne	Frederick	Frederick

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
551-26-3403	1☐ M 2☒ F	80 Yrs.			February 14, 1921	California

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Ijamsville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9909 Ritchie Drive	21754	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Samuel Bloomer	Jesse Lincoln

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Charles B. Glover/Husband	9909 Ritchie Drive, Ijamsville, Maryland, 21754

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Smithsburg Crematory	11/19/2001	Smithsburg, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ P. Ryan McMillan MO1202	Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. dehydration	5 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): dementia	15 yrs
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D53129	November 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dale Heitzig, MD, 610 Solarex Ct. Frederick MD 21703

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

3

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 2 0 2001	▶ Geneva B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amended item#23a per MD FCHD **Certificate of Death** KS Reg. No. 2001 38661

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
LESTER WILLIAM HANEY	November 17, 2001	5:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sunrise Assisted Living	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
176-14-8315	1☒M 2☐F	80 Yrs.			April 7, 1921	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
990 Waterford Drive	21702	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WWII	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Production Control Supervisor	Research Cottrell Inc.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Lester Melvin Haney	Elizabeth O'Connor

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lester R. Haney (Son)	1006 Mercer Place, Frederick, Maryland 21701

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Smithsburg Crematory	11/20/01	Smithsburg, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert E. Dailey	ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Aspiration Stroke	10 years
	c. Due to (or as a consequence of): Stroke	10 years
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Assisted Living

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D0035152	11-19-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. L. KRANTZ, MD 180 Thos. Johnson Dr. Frederick, MD 21702

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item #26 per VERBAL 6802 12/04/01 EW

Certificate of Death

Reg. No. 2001 38662

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Paul Elijah Hoye

2. Date of Death (Month, Day, Year): November 4, 2001

3. Time of Death: 12:31 a.m.

4a. Facility Name (If not institution, give street and number): 2578 Hoyes Run Road

4b. City, Town, or Location of Death: McHenry

4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 220-26-9429

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec 30, 1925

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Garrett

10c. City, Town or Location: McHenry

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2578 Hoyes Run Road

10f. Zip Code: 21541

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 7/44-7/46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Stone Quarry

17. Father's Name (First, Middle, Last): Frederick Hoye

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth (Hoye)

19a. Interment's Name/Relationship (Type, Print): Violet R. Hoye/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2578 Hoyes Run Rd., McHenry, MD 21541

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrett Co. Mem. Gardens

Date: Nov 7,01

20c. Location - City or Town, State: Oakland, MD

21. Signature of Funeral Service Licensee: D Lyn Daman

22. Name and Address of Facility: Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Myelocytic Leukemia	6 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) ~~Hospice~~

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Karl E. Schwalm MD

29c. License number: D27205

29d. Date signed (Month, Day, Year): Nov 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Karl E. Schwalm, M.D. 311 N. Fourth Street Oakland, MD 21550

State Registrar

31. Date filed (Month, Day, Year): NOV - 6 2001

32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

GARRETT #36

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#23a per PHYG802 12/04/01 EW

Certificate of Death

Reg. No. 2001 38663

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
EDWARD	JAMES	HARTMAN	NOVEMBER 8, 2001	1110 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
178-24-1840	1☒M 2☐F	70 Yrs.			JUNE 30, 1931	PENNSYLVANIA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
DELAWARE	SUSSEX	SELBYVILLE	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
29 GRANT AVENUE	19975	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1949-53	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	TECHNICAL WRITER	ELECTRONICS

17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)	
RAYMOND	J.	HARTMAN	MARY	STECKBECK

19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
FAYE E. HARTMAN/WIFE	29 GRANT AVENUE, CAPE WINDSOR, SELBYVILLE, DE. 19975

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MILLSBORO VETERANS CEM.	11/13/01	MILLSBORO, DELAWARE

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	HEART FAILURE ~~MULTI-ORGAN SYSTEM FAILURE~~	~~72 hrs.~~
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of): RENAL FAILURE	
	b. Due to (or as a consequence of): CARDIOMYOPATHY	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
RKD	H0015697	11/8/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROBERT COKER, M.D. 100 E CARROLL ST. SALISBURY, MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 13 2001	Penny B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

EDWARD HARTMAN

W.C. #23A

10+ IVA DQ

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38664

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANK ROBERT HUDSON

2. Date of Death: Month 11 Day 17 Year 2001

3. Time of Death: 10:30 A.M.

4a. Facility Name (If not institution, give street and number): 110 Purnell St.

4b. City, Town, or Location of Death: Snow Hill

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 222-03-2080

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 27, 1917

9. Birthplace (State or Foreign Country): DELAWARE

Usual Residence of Decedent

10a. State: Maryland

10b. County: Worcester

10c. City, Town or Location: Snow Hill

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 110 Purnell St.

10f. Zip Code: 21863

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [XX] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FURNACE HANDYMAN

16b. Kind of Business/Industry: BUILDING CONSTRUCTION

17. Father's Name (First, Middle, Last): GEORGE HUDSON

18. Mother's Name (First, Middle, Maiden Surname): IDA KING

19a. Informant's Name/Relationship (Type, Print): BONNIE H. MESSICK/GREAT NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26578 ASBURY ROAD, SEAFORD, DE 19973

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): EASTERN SHORE CREMATORIUM | Data: 11/20/01

20c. Location - City or Town, State: LEWES, DELAWARE

21. Signature of Funeral Service Licensee: M00866 — Scott Parsell

22. Name and Address of Facility: PARSELL FUNERAL HOMES & CREMATORIUM, 1449 KINGS HIGHWAY, LEWES, DE 19958

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or raspiratory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASCVD — SEVERAL YRS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequance of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

PROSTATIC CA

ETHAMOLISM

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: Dorothy C. Holzworth, M.D.

29c. License number: D06241

29d. Date signed (Month, Day, Year): 11-19-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DOROTHY C. HOLZWORTH, M.D. 203 SNOW ST. SNOW HILL, MD 21863

State Registrar

31. Date filed (Month, Day, Year): DEC - 4 2001

32. Registrar's Signature: Donna D Toads

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38665

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sadie Estella McCarty Kemp
2. Date of Death: Month 10 Day 31 Year 01
3. Time of Death: 8 P.M.
4a. Facility Name (If not institution, give street and number): 5804 Catoctin Vista Drive
4b. City, Town, or Location of Death: Mt. Airy
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 578-07-5975
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-12-1910
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Frederick
10c. City, Town or Location: Mt. Airy
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5804 Catoctin Vista Drive
10f. Zip Code: 21771
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: The Home

17. Father's Name (First, Middle, Last): John William McCarty
18. Mother's Name (First, Middle, Maiden Surname): Lula Mae Martz

19a. Informant's Name/Relationship (Type, Print): William T. Kemp, Jr./Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5804 Catoctin Vista Drive, Mt. Airy, MD 21771

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ebenezer Cemetery
Date: 11-2-01
20c. Location - City or Town, State: Round Hill, VA

21. Signature of Funeral Service Licensee: Carl Nicholson
22. Name and Address of Facility: Hall Funeral Home, P.O. Box 896, Purcellville, VA 20134

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cerebral Vascular Accident	1 month
Due to (or as a consequence of): b.	Hypertension	20+ years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Congestive Heart Failure	6 months
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James J. Grisson MD
29c. License number: D21944
29d. Date signed (Month, Day, Year): 11/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James J. Grisson MD 300 W 9th St. Frederick, MD.

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001
32. Registrar's Signature: Denise G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38666

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stoll Detrick Kemp
2. Date of Death (Month, Day, Year): November 18, 2001
3. Time of Death: 6:55 PM
4a. Facility Name (If not institution, give street and number): Homewood at Crumland Farms
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-20-3116
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 14, 1904
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 7404 Willow Drive
10f. Zip Code: 21702
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Antique Dealer
16b. Kind of Business/Industry: Antiques

17. Father's Name (First, Middle, Last): David Chester Kemp
18. Mother's Name (First, Middle, Maiden Surname): Sophia Detrick

19a. Informant's Name/Relationship (Type, Print): Elizabeth Kemp Roszel/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3403 Oakenshaw Place, Baltimore, Maryland 21218

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory
Date: Nov. 19, 2001
20c. Location - City or Town, State: Smithsburg, MD.

21. Signature of Funeral Service Licensee: Richard C. C. Basford M00021
22. Name and Address of Facility: Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic Heart Disease	years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Cancer of Prostate

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: Casper E. Cline III MD
29c. License number: D16428
29d. Date signed (Month, Day, Year): November 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Casper E. Cline, III, M.D., 300 West Ninth Street, Frederick, MD 21701

State Registrar

31. Date filed (Month, Day, Year): NOV 2 0 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #27, 11/9/2001, EMW, Montg. Co. **Certificate of Death** Reg No. 2001 38667

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
KYONG KANG			November 02 2001	2315 M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
University of Maryland Medical Center	BALTIMORE		Baltimore City	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-98-3568	1 ☐ M 2 ☒ F	42 Yrs.			JULY 15, 1959	KOREA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	PRINCE GEORGE'S	CALVERTON	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3308 STONEHALL DRIVE	20705	UNITED STATES OF AMERICA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: ASIAN

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
POK DONG PARK	POK SOON PARK

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
HYUNG JOO KANG (HUSBAND)	3308 STONEHALL DRIVE; CALVERTON, MARYLAND 20705

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	GATE OF HEAVEN CEMETERY	NOV. 07, 2001	SILVER SPRING, MARYLAND

21. Signature of Funeral Service Licensee: Jno. J. Rinaldi

22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MARYLAND 20904-2891

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Hemmorhagic Shock	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Multi System Organ Failure	
	Due to (or as a consequence of):	
	c. Cryptogenic Fulminant Hepatic Failure	7 days
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Septal Defect

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

28. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation ~~6 ☒ Could not be determined~~

28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Christine Brand, MD	D0057634	11/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christine Brand, MD University of Maryland Medical System

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 09 2001	Geneva G. Boarman

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Mont #234

5

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amended item#26perMD FCHD,KS

Certificate of Death

Reg. No. 2001 38668

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month Day Year	3. Tima of Daath
Richard	Lewis	Lee	November 17, 2001	7:30p M

4a. Facility Nama (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
606 Wyngate Drive	Frederick	Frederick

5. Social Security Number	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Yaar)	9. Birthplace (State or Foraign Country)
579-22-1909	1☒M 2☐F	92 Yrs.			Apr 7, 1909	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Insida City Limits
Florida	St. Lucy	Fort Pierce	1☐Yes 2☒No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
113 Yacht View Lane	34946	U.S.A.

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.)	14. Race - Americen Indian, Black, Whita, atc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yas 2☒No If Yes, Giva Year or Datas:	1☐Yas 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Farmer	Agriculture

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middla, Maiden Sumame)
Philip D. C. Lee	Zelia R Baden

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Code)
Richard Lee, Son	9620 Ridge View Drive, Marshall, Virginia 20115

20a. Method of Disposition	20b. Place of Disposition (Nama of cematery, crematory or othar placa)	Date	20c. Location - City or Town, Stata
1☒Burial 2☐Cremation 3☐Removal from Stata 4☐Donation 5☐Other (Specify)	Chestnut Grove	Nov 20, 2001	Herndon, Virginia

21. Signatura of Funeral Service Licensa	22. Name and Address of Facility
Kathryn Roberts M00706	Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona causa on aach lina.

Approximate Interval Between Onsat and Daath

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart failure — 3 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic monomyelocytic leukemia — 3 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcoma of pregnancy 1☐Live birth 2☐Fetal daath 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Othar (specify) 9☐Unknown	23d. Data of dalivery Month Day Yaar

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying cause given in Part I.

Aortic valve replacement

23e. Did tobacco usa contributa to the causa of daath? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings availabla prior to completion of cause of death? 1☐Yas 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No	26. Placa of Death (Check only ona) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Othar: 4☐Nursing Homa 5☒Residence 6☐Othar (Specify) Caretaker's Residence

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28a. Data of Injury (Month, Day Yaar)	28b. Tima of Injury M	28c. Injury at Work? 1☐Yas 2☐No	28d. Dascribe how injury occurred

28e. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify)	28f. Location (Street and Numbar or Rural Route Numbar, City or Town, Stata)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, date and placa, and dua to tha causa(s) and mannar as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to tha causa(s) and mannar stated.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
▶ Austin Pearre	D09689	11/19/01

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

A. Austin Pearre, Jr, M.D., 300 West Ninth Street, Frederick, Maryland 21701

30

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
NOV 20 2001	▶ Bonnie B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38669

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
RICHARD PAUL LINNÉ	November 20, 2001	5:40 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1405 Key Parkway / Apt. C 206	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
177-20-1282	1[X] M 2[ ] F	70 Yrs.			December 25, 1930	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Frederick	Frederick	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1405 Key Parkway Apt. C 206	21702	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced	1[X] Yes 2[ ] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Safety Inspector	Nuclear Plant

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Linné	Theresa Fugazzi

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ann Moxley/Wife	1405 Key Parkway Apt. C 206 Frederick, MD 21702

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[ ] Burial 2[X] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	Hagerstown Crematory	Nov. 21, 2001	Hagerstown, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Jacqueline Kuhn	Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pancreatic lung cancer	1 yr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as e consequence of):	
	d.	

tF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of deeth 5[ ] Other (specify) _____ 9[ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[X] Yes 2[ ] No 3[ ] Probably 4[ ] Unknown	1[ ] Yes 2[X] No	1[ ] Yes 2[ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1[ ] Yes 2[X] No	Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA	Other: 4[ ] Nursing Home 5[X] Residence 8[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[ ] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D14529	Nov 21, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
G Rogers 501 W 7th Frederick MD 21701

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 21 2001	Penny B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

OK per Earl 11-21 2:45 pl

1of1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar: Amend Item#26 per VERBALG 802 12/04/01 EW

Certificate of Death

Reg. No. 2001 38670

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
June	V.	Larson	November 16, 2001	5:45 AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
27733 Oriole Road	Princess Anne	Somerset

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
229-54-6734	1 M 2 X F	70 Yrs.			06/04/1931	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
AL	Baldwin	Foley	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11852 Woodland Avenue	36535	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 Yes 2 X No	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	none	Secretary/Stock Broker	Stock Brokerage

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Guy S. Vessey	Ethel Massey

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Karen C. Poisker/Daughter	27733 Oriole Road, Princess Anne, MD 21853

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Salisbury Crematory	11/16/2001	Salisbury, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
James L Hinman M00295	Hinman Funeral Home 11673 Somerset Ave., Princess Anne, MD 21853

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Bronchiectasis

Due to (or as a consequence of):
b. Chronic Respiratory Insufficiency

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 Yes 2 X No 9 Unknown	1 Live birth 2 Fatal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 3 Probably 4 X Unknown	1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	27. Manner of Death
1 Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 X Residence 6 X Other (Specify) Daughter's Residence	1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	H54827	11/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mitchell S. Gittelman D.O. 106 S. Milford St Ste 201 Salisbury, Md 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	D. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Summers Tue 26

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#24a perVERBALG802 12/04/01 EW

Certificate of Death

Reg. No. 2001 38671

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Anna Rosella Lucas	November 17, 2001	11:15 p.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Williamsport Nursing Home	Williamsport	Washington

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-28-5742	1☐ M 2☒ F	84 Yrs.			July 2, 1917	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Washington	Williamsport	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
154 North Artizin Street	21795	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
N/A		Cafetria	Washington County Board of Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Earl Miller Sr.	Minnie Bell

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Cynthia D. Lucas / Daughter	42 East North Ave, Hagerstown, Md. 21740

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Cedar Lawn Memorial Park	November	21,2001 Hagerstown,Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Eric L. Brown Eric L. Brown	Rest Haven Funeral Home 1601 Pennsylvania Ave Hagerstown, Md. 21742

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. EXSANGUINATION	MINUTES
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. ACUTE PULMONARY HEMORRHAGE	MINUTES
Due to (or as a consequence of):		
	c. METASTATIC LUNG CARCINOMA	1 YEAR
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ T E Howe MD	D33700	NOVEMBER 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TED HOWE 154 N. ARTIZAN STREET, WILLIAMSPORT, MD 21795

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	▶ Brenda D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

WASH 3 4/A

GAP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38672

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
William Joseph Miller, Jr.	November 19, 2001	1635 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6200 J Glen Valley Terrace	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-46-2654	XX 1 M 2 F	54 Yrs.			March 20, 1947	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	X 1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6200 J Glen Valley Terrace	21701	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 XX Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 XX No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	+5	Supervisor	Board of Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Joseph Miller, Sr.	Anna Murray

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ms. Ann Reever, Fiancee	6200 J Glen Valley Terrace, Frederick, Md. 21701

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place) / Date	20c. Location - City or Town, State
1 Burial 2 XX Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Smithsburg Crematory, Nov. 21, 2001	Smithsburg, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Richard E. Ibrey M00255	Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive ASCVD — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? XX Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 XX No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 XX No

26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 XX Residence 8 Other (Specify)

27. Manner of Death XX 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
XX 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D0050880	November 20, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
N. David Tzou, M.D., 56 Thomas Johnson Drive, Frederick, Maryland 21702

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 21 2001	▶ Penny B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#27 perPHYG802 12/13/01 EW

Certificate of Death

Reg. No. 2001 38673

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDWARD J. MERCER

2. Date of Death: Month 11 Day 17 Year 01

3. Time of Death: 1300

4a. Facility Name (If not institution, give street and number): Dorchester General Hospital

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 157-09-1035

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 2, 1919

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedant

10a. State: MD

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 804 Travers St. Apt. 1

10f. Zip Coda: 21613

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): plant worker

16b. Kind of Business/Industry: manufacturing

17. Father's Name (First, Middle, Last): Frederick Mercer

18. Mother's Name (First, Middle, Maiden Surname): Anna unknown

19a. Informant's Name/Relationship (Type, Print): Bruce D. Willey - p.r.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt 1 Box 335H, Seaford, DE 19973

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Maryland Veterans Cemetery | Date: 11/20

20c. Location - City or Town, State: Hurlock, Maryland

21. Signature of Funeral Service Licensee: John W. Thomas

22. Name and Address of Facility: Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Massive Intracerebral Hemorrhage — Hours

Due to (or as a consequence of):

b. Hypertension — Years

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Cardiac Disease — Years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

Cardiac disease

History of Colon Cancer

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residance 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dsookal MD

29c. License number: D0057067

29d. Date signed (Month, Day, Year): 11/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAMIAN SOOKRAL, M.D 607 Dutchman's Lane, Easton MD 21601

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

#27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar: Amend Item#23a per PHY G802 12/04/01 EW

Certificate of Death

Reg. No. 2001 38674

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Ronald	J.	Melendez	November 9 2001	4:20 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FRANKLIN SQUARE HOSPITAL	Rosedale	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
188-56-7308	1☒ M 2☐ F	38 Yrs.			Jan 25, 1963	York, PA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
PA	York	Manchester	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5 Fairmont Avenue	17345	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Staff Accountant	Steel Products Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ricardo Melendez	Patricia A. Hoke Kifer

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ricardo Melendez - Father	5265 North George St. Ext'd. Manchester, PA 17345

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Susquehanna Mem. Gdns.	11/17/01	York, Pennsylvania

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Allen J. Woodall	Metropolitan Funeral Service 5517 Vine At. Alexandria, VA

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis / Peritonitis	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): PERITONITIS b. ~~Bypass Anastamosis Leak~~ Due to (or as a consequence of): BYPASS ANASTOMOSIS LEAK c. Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
M Chatham	D20907	November 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR MARIC CHATHAM 9000 FRANKLIN SQUARE DR. BALTIMORE MD 21237

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 13 2001	Geneva G. Banks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Ronald Melendez

#23a Mort

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#23a perPHYG802 12/04/01 EW

Certificate of Death

Reg. No. 2001 38675

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harry Seibert Murray

2. Date of Death: Month October Day 11 Year 2001

3. Time of Death: 10:35 P.M.

4a. Facility Name (If not institution, give street and number): Goodwill Mennonite Home

4b. City, Town, or Location of Death: Grantsville

4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 212-18-1415

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 20, 1911

9. Birthplace (State or Foreign Country): Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Garrett

10c. City, Town or Location: Grantsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 12408 National Pike

10f. Zip Code: 21536

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Dairy Products

17. Father's Name (First, Middle, Last): George Murray

18. Mother's Name (First, Middle, Maiden Surname): Edna J. Long

19a. Informant's Name/Relationship (Type, Print): Charles Murray, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10882 National Pike, Grantsville, MD 21536

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Grantsville Cemetery, Date: Oct 14, 2001

20c. Location - City or Town, State: Grantsville, MD 21536

21. Signature of Funeral Service Licensee: Ruth K. Newman

22. Name and Address of Facility: Newman Funeral Homes, P.A. 179 Miller St., P.O. Box 275, Grantsville, MD 21536

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Subdural Hematoma — 1 MONTH

Due to (or as a consequence of):

b. ~~FALL~~ — ~~1 MONTH~~

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation
Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robin Bissell MD

29c. License number: D-34231

29d. Date signed (Month, Day, Year): October 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Robin Bissell, M.D., 124 Miller Street, Grantsville, MD 21536

State Registrar

31. Date filed (Month, Day, Year): OCT 12 2001

32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Garrett #23

6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38676

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROGER WILLIAM REMSBURG
2. Date of Death: Month NOVEMBER Day 20 Year 2001
3. Time of Death: 8:37am
4a. Facility Name (If not institution, give street and number): PLEASANT VIEW NURSING HOME
4b. City, Town, or Location of Death: MT. AIRY
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 217-36-8229
6. Sex: 1☑M 2☐F
7. Age (In yrs. last birthday): 60 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB 4 1941
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: FREDERICK
10c. City, Town or Location: FREDERICK
10d. Inside City Limits: 1☐Yes 2☑No
10e. Street and Number: 4529 ARABY CHURCH RD.
10f. Zip Code: 21701
10g. Citizen of What Country: USA

11. Marital Status: 1☐Never Married 2☑Married 3☐Widowed 4☑Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☑Yes 2☐No If Yes, Give Year or Dates: 1960-1964
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☑No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STOCKER
16b. Kind of Business/Industry: GROCERY

17. Father's Name (First, Middle, Last): OWEN J. REMSBURG
18. Mother's Name (First, Middle, Maiden Surname): MYRTLE L. BEALL

19a. Informant's Name/Relationship (Type, Print): FRANK REMSBURG / BROTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O BOX 163, FREDERICK, MD 21701

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PLEASANT VIEW CEMETERY — Date: 11/23
20c. Location - City or Town, State: BURKITSVILLE, MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: HILTON FUNERAL HOME, BOX 86, BARNESVILLE, MD 20838

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaasa or condition resulting in death)
a. EMPHYSEMA — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated evants resulting in death) Last
b. CIGARETTE SMOKING

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the causes of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of causa of death? 1☐Yes 2☐No

25. Was ceae referred to medical examinar? 1☐Yes 2☑No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D26499
29d. Date signed (Month, Day, Year): NOVEMBER 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ronald E Miller, M.D. 4 Culwell Dr. Mt Airy MD 21771

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD

01-6157-047

MICHAEL PALMISANO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38677

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Michael Anthony Palmisano

2. Date of Death Month/Day/Year: OCTOBER 31, 2001

3. Time of Daeth: 6:50A. M

4a. Facility Name *(If not institution, give street and number)*: 5520 JOYNER ROAD

4b. City, Town, or Location of Death: SNOW HILL

4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 212-60-0432

8. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 48 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 10, 1952

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Dorchester

10c. City, Town or Location: Federalsburg

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 6726 Eldorado Road

10f. Zip Code: 21632

10g. Citizen of What Country?: United States

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☒☒Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter

18b. Kind of Business/Industry: Residential

17. Father's Name *(First, Middle, Last)*: Anthony Palmisano

18. Mother's Name *(First, Middle, Maiden Surname)*: Jean Palmisano

19a. Informant's Name/Relationship *(Type, Print)*: Gail L. Wahl/Companion

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6726 Eldorado Rd., Federalsburg, MD 21632

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from Stete 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cambridge Crem.

Date: 11/3/01

20c. Location - City or Town, State: Cambridge, Maryland

21. Signature of Funeral Service Licensee: Christine M. Veale

22. Name and Address of Facility: Framptom-Hawkins-Eskow Funeral Home, PA Federalsburg, MD 21632

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HANGING

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

If FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other *(specify)* 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

28. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other *(Specify)* SCENE

27. Manner of Death: 1☐Natural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*: 10/31/01

28b. Time of Injury: 6:30 A M

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: SUBJECT HANGED SELF

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: WORCESTER COUNTY JAIL

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 5520 JOYNER ROAD SNOW HILL, MD

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. M. T.

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: NOVEMBER 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TINUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 0 2 2001

32. Registrar's Signature: Donna B. Spacht

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38678

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
MAURJA Lanique RICH	November 15 2001	0210 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Hospital	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-61-5792	1 M 2 F	Yrs.	6	12			April 27, 2001	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Dorchester	Cambridge	1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
620 Schoolhouse Lane	21613	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	Never Worked	None
9			

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
Maurice Lavar Rich	Monica Stanley

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Monica Stanley-Rich	620 Schoolhouse Lane Cambridge, Maryland 21613

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Waugh Cemetery	11/21/2001	Cambridge, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Janelle C. Henry	Henry Funeral Home P.A. 510 Washington St. Cambridge, Maryland 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pulmonary Hypertension	6 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Congenital Hypoplastic Right Lung and Pulmonary Vasculature	6 months
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	RES-000	November 15 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michelle Smith, MD Johns Hopkins Hospital 600 North Wolfe Street, Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38679

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Chester LeRoy Stone

2. Date of Death (Month, Day, Year): November 15, 2001

3. Time of Death: 12:11 A M

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 215-34-1843

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sep 17, 1918

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 6407 Ford Road

10f. Zip Code: 21702

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1941-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

18b. Kind of Business/Industry: Construction Services

17. Father's Name (First, Middle, Last): Frank Stone

18. Mother's Name (First, Middle, Maiden Surname): Mary Frances Elizabeth Blank

19a. Informant's Name/Relationship (Type, Print): Mrs. Shirley Morgan Stone/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6407 Ford Road, Frederick, Maryland 21702

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Resthaven Mem Gardens

Date: Nov 17,2001

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Keith Lynn Roberson M00706

22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. dehydration

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. esophageal cancer

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dale Heitzig MD

29c. License number: D53129

29d. Date signed (Month, Day, Year): 11/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DALE HEITZIG MD 610 SOLAREX CT FREDERICK MD 21703

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State Registrar

31. Date filed (Month, Day, Year): NOV 19 2001

32. Registrar's Signature: B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM#10a-10c&10e&f PER F.H. 6806 4-8-02 JAB

Certificate of Death

Reg. No. 2001 38680

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Jairus W Staton	11	18	01	3:32 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland	Baltimore	Baltimore City

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-50-5083	1 X M 2 F	46 Yrs.					08/06/55	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
~~WV~~ MD.	~~Berkeley~~ FREDERICK	~~Falling Waters~~ FREDERICK	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
~~310 Imperial Way~~ 427 SOUTH MARKET STREET	~~25419~~ 21701	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 X Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Truck Driver	United Concrete Block

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Jairus W. Staton, Sr.	Audrey Bernice Shultz

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Linda Ferree (Sister)	427 South Market Street, Frederick, MD 21701

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Mount Olivet Cemetery	11/21/01	Frederick, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Robert E. Dailey	ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No 3 Probably 4 Unknown	1 Yes 2 X No	1 Yes 2 X No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Ronald Goodwich, MD	A4417643SG13808	11/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ronald Goodwich, MD 22 S. Greene St Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	Penny B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38681

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Doris E. Bender Skinner	November 19, 2001	0035 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington County Hospital	Hagerstown	Washington

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
486-42-3592	1☐M 2☒F	61 Yrs.			April 2, 1940	Missouri

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Washington	Boonsboro	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8114 Mapleville Road	21713	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	1	supervisor	medical field

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Orville Edwards	Bernice Stults

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sue Mahone / daughter	8114 Mapleville Rd., Boonsboro, MD 21713

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Resthaven Mem. Gardens	11/23/01	Frederick, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jacqueline Krell	Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Septic shock	24°
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Cellulitis (R) foot	48°
	Due to (or as a consequence of): c. Diabetes	25yrs.
	Due to (or as a consequence of): d.	

If FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

sarcoidosis COPD sleep apnea.
steroid dependence for sarcoidosis

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D56413	11/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Saxena 3 Byrkit Dr. Williamsport, md 21795

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	▶ Saxena by Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38682

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Nellie Effie Shaw	November 19, 2001	4:15 AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Beverly Health Care of Frederick	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-10-2180	1☐M 2☒F	93 Yrs.			July 8, 1908	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizan of What Country?
324 East Church Street	21701	U.S.A.

11. Marital Status	12. Was Decedant Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Seamstress	Clothing Factory

17. Father's Nama (First, Middle, Last)	18. Mother's Nama (First, Middle, Maiden Surnama)
Clark Wenner	Ida Schwaigert

19a. Intormant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)
Mrs. Kathy J. Kinnaman, niece	810 Chadwick Circle, Frederick, Maryland 21701

20a. Method of Disposition	20b. Placa of Disposition (Name of cematary, crematory or other placa)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Mount Olivet Cemetery,	Nov. 21, 2001	Frederick, Maryland

21. Signature of Funeral Service Licensee	22. Nama and Address of Facility
▶ Richard E. Sharp M00255	Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha daath. Do not antar the mode of dying, such as cardiac or raspiratory errast, shock, or haart failure. List only one cause on each line.

		Approximata Interval Between Onset and Daath
Immediate Cause (Final diseasa or condition resulting in death)	a. End Stage Alzheimers	10 Years
Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disaase or injury that initiated avents resulting in death) Last	Due to (or as a consequence of): b. Hypertension	20 Years
	Due to (or as a consequance of): c.	
	Due to (or es e consequence of): d.	

IF FEMALE: 23b. Was decedant pregnant in tha past 12 months?	23c. If yes, outcome of pregnancy	23d. Data of dalivary
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at tima of daath 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

Glucoma, COPD

Immobility Syndrome

Failure to thrieve

23e. Did tobacco use contribute to the causa of death?	24a. Was an autopsy performed?	24b. Ware autopsy findings available prior to completion of cause of deeth?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yas 2☒No

25. Was case retarred to medical axaminar?	26. Placa of Daath (Check only ona)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Othar: 4☒Nursing Home 5☐Residenca 6☐Othar (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yaer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicida 5☐Pending investigation 6☐Could not ba determined		M	1☐Yas 2☐No	

28e. Placa of Injury - At homa, farm, straat, tactory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurrad at the time, data and placa, and due to the cause(s) and mannar as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Allen Reilly MD	D 54749	November 19, 2001

30. Name and address of person who completed causa of daath (Item 23a) (Typa, Print)
Allen Reilly, M.D., 30 North Place, Frederick, Maryland 21701

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	▶ Benna B Sparks

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38683

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Anna Smith
2. Date of Death (Month, Day, Year): Oct 31 2001
3. Time of Death: 5:10 PM
4a. Facility Name (If not institution, give street and number): Genesis ElderCare - The Pines
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 218-40-5411
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 3 1926
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Queen Anne
10c. City, Town or Location: Grasonville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 104 Maple Drive
10f. Zip Code: 21638
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Henry Kemp
18. Mother's Name (First, Middle, Maiden Surname): Ida Mae Walls

19a. Informant's Name/Relationship (Type, Print): Donna L. Ruth/ daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 394 Ridgley, MD 21660

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Greensboro Cemetery
Date: 11/3
20c. Location - City or Town, State: Greensboro, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Fleegle and Helfenbein Funeral Home, PA
P.O. Box 160 Greensboro, MD 21639

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Gangrene R leg	3 mos
Due to (or as a consequence of):	Peripheral Vascular Disease	10 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HTN with Chronic Congestive Failure
Cerebrovascular Disease with Left Hemiplegia

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William Wood MD
29c. License number: D08715
29d. Date signed (Month, Day, Year): 11/1/01

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print): WILLIAM WOOD, MD 505 DUTCHMAN'S LANE EASTON, MD 21601

State Registrar

31. Date filed (Month, Dey, Year): NOV 0 5 2001
32. Registrar's Signature: Debra G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Ruth Smith
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38684

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Hazelton St. Clair JR.
2. Date of Death Month / Day / Year: 11 / 15 / 2001
3. Time of Death: 2 32 PM

4a. Facility Name (If not institution, give street and number): Dorchester General Hospital
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 214-07-9230
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 06, 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 625 Douglas Street
10f. Zip Code: 21613
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Year or Dates: 1942 1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Convenience Store Work
16b. Kind of Business/Industry: Entrepreneur

17. Father's Name (First, Middle, Last): Edward Hazelton St. Clair, SR.
18. Mother's Name (First, Middle, Maiden Surname): Emma Slater

19a. Informant's Name/Relationship (Type, Print): Gladys Cornish
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5384 Aireys Road Cambridge, Maryland 21613

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Veteran's Cemetery
Date: 11/20/2001
20c. Location - City or Town, State: Hurlock, Maryland

21. Signature of Funeral Service Licensee: ▶ Janelle C. Henry
22. Name and Address of Facility: Henry Funeral Home P.A. 510 Washington Street Cambridge, Maryland 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Prostate Cancer — 6 mont.
Due to (or as a consequence of):
b. Dehydration — 3 days.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: ☒ 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ☒ 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. ☐ 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Mehta attendg physician
29c. License number: D13341.
29d. Date signed (Month, Day, Year): 11/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vinodrai Mehta, M.D., 402 Byrn Street, Cambridge, MD 21613

State Registrar

31. Date filed (Month, Day Year): NOV 20 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38685

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Victor Herbert Showalter
2. Date of Death: Month 11 Day 17 Year 01
3. Time of Death: 1338
4a. Facility Name (If not institution, give street and number): Dorchester General Hospital
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 293-18-6170
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 9, 1914
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5706 Glasgow Court
10f. Zip Code: 21613
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): accountant
16b. Kind of Business/Industry: steel industry

17. Father's Name (First, Middle, Last): Victor Charles Showalter
18. Mother's Name (First, Middle, Maiden Surname): Dollie Mowrey

19a. Informant's Name/Relationship (Type, Print): Gertrude Showalter - wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5706 Glasgow Court, Cambridge, MD 21613

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Salisbury Crematory
Date: 11/18
20c. Location - City or Town, State: Salisbury, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Aspiration Pneumonia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Shy-Drager Syndrome
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: History of Congestive Heart Failure; History of Hypotension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D0057067
29d. Date signed (Month, Day, Year): 11/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAMIAN SOOKLAL, M.D. 607 DUTCHMAN'S LANE, EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar: Amend Item#26 perVerbal G802 12/04/01 EW

Certificate of Death

Reg. No. 2001 38686

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Josephine	Roberta	STEYER	Nov. 7, 2001	5:31 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1304 Steyer Mine Road	Oakland	Garrett

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-56-8995	1☐ M 2☒ F	84 Yrs.			July 17, 1917	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Garrett	Oakland	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1304 Steyer Mine Road	21550	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Packer	Lens Manufacturing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
A. Scott HARVEY	Nora Lucinda SOLOMON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William S. Steyer/Son	1165 Steyer Mine Road, Oakland, Md. 21550

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Garrett Co. Mem. Grdns	11/10/01	Oakland, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Bradley A. Stewart	Stewart Funeral Home 32 S. Second St. Oakland, Md. 21550

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Breast Carcinoma	Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) ~~Hospice~~

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D15333	11/9/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Thomas G. Johnson M.D. 311 N. 4th St., Oakland, Md. 21550

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV - 9 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

GARRETT #26

15

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Item#9 perFH
Amend Item#23a perPHYG802 12/04/01 EW

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38687

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JENNIFER CATHERINE SCHUCKER	OCTOBER 20, 2001	7AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HOLY CROSS HOSPITAL	SILVER SPRING	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
036 42 8065	1☐ M 2☒ F	44 Yrs.			DEC.12,1956	Unknown

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	MONTGOMERY	SILVER SPRING	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10120 NEW HAMPSHIRE AVE. #308	20903	UNITED STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Navar Married 2☐ Married 3☐ Widowed 4☒ Divorcad	1☐ Yes 2☒ No If Yas, Give Yaar or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highast grada completed)		16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elemantary/Secondary (0-12)	College (1-4or 5+)		
12	0	ACCOUNTANT	ACCOUNTING

17. Fathar's Nama (First, Middle, Last)	18. Mother's Nama (First, Middle, Maiden Surname)
ROBERT McBRIDE SCHUCKER	PRISCILLA ALDEN WYANT

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PAUL SCHUCKER (UNCLE)	1025 SEXTANT CT. ANNAPOLIS,MD. 21401

20a. Method of Disposition	20b. Placa of Disposition (Name of cematary, cramatory or other place)	Date	20c. Location - City or Town, Stata
1☐ Burial 2☒ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)	METROPOLITAN CREMATORY	10-21-01	ALEXANDRIA,VA.

21. Signatura of Funaral Service Licensee ▶ [signature]

22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER,MD.21037

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only ona cause on aach line.

		Approximata Interval Between Onset and Death
Immediate Cause (Final disaasa or condition resulting in death)	a. ~~CARDIOPULMONARY ARREST~~ PANCREATITIS	~~MINUTES~~ DAYS
Dua to (or as a consequence of):		
Sequantially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Dua to (or as a consequence of):		
	c.	
Dua to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

LUPUS

~~PANCREATITIS~~

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was casa rafarred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Rasidance 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, data and place, and due to tha cause(s) end mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signatura and title of certifier	29c. Licanse number	29d. Date signed (Month, Day, Year)
▶ [signature] M.D.	D14609	OCTOBER 20,2001

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print)
MILTON KOCHE 10801 LOCHWOOD DRIVE SILVER SPRING,MD. 20901

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signatura
OCT 23 2001	[signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funeral director, paga 2 should be detached for usa as tha burial-transit

AA#234

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38688

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Jacob Tonik
2. Date of Death (Month Day Year): November 15, 2001
3. Time of Death: 2:23pm

4a. Facility Name (If not institution, give street and number): 6332 Quinn Road
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-98-6016
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 20 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 9, 1981
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6332 Quinn Road
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seafood Customer Service
16b. Kind of Business/Industry: Grocery Market

17. Father's Name (First, Middle, Last): David Alan Tonik
18. Mother's Name (First, Middle, Maiden Surname): Frances Louise Gue

19a. Informant's Name/Relationship (Type, Print): Mrs. Frances L. Tonik/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6332 Quinn Road, Frederick, Maryland 21701

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hagerstown Crematory | Date: Nov 16, 2001
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Heather Lynn Robertson M00706
22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Morbid Obesity
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Andrew Zarick Jr
29c. License number: D35164
29d. Date signed (Month, Day, Year): November 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Zarick, Jr, M.D., 1080 West Patrick Street, Frederick, Maryland 21703

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001
32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38689

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Pauline	Cornelia	VanPelt	October 31, 2001	5:16 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-24-8958	1☐M 2☒F	89 Yrs.			May 22, 1912	MD.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	Frederick	Middletown	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
711 E. main St.	21769	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	teacher	public schools

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John VanPelt	Hannah Brown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Faith V. Hoover (Friend)	711 E. Main St., Middletown, MD. 21769

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	St. Luke's Cemetery	11/3	Brownsville, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD. 21769

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. pneumonia	3 days
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure, Cranial Hemorrhage

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ K. Holland MD	D43380	10/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kevin E. Holland MD 300 S. church st. Middletown MD 21769

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State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 05 2001	▶ Bernice G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38690

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gloria Louise Work

2. Date of Death: Month November Day 15 Year 2001

3. Time of Death: 4:20 A M

4a. Facility Name (If not institution, give street and number): 13106 Kara Lane

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-24-0423

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 11, 1923

9. Birthplace (State or Foreign Country): Washington, DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 13106 Kara Lane

10f. Zip Code: 20904

10g. Citizen of What Country?: United States

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Budget Analyst

16b. Kind of Business/Industry: District of Columbia Government

17. Father's Name (First, Middle, Last): Allen H. Work

18. Mother's Name (First, Middle, Maiden Surname): Eva Windsor

19a. Informant's Name/Relationship (Type, Print): Braden L. Work / Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9403 Highlander Blvd. Walkersville, Maryland 21793

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Resthaven Mem. Gardens

Date: November 17, 2001

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer Stage IV and Metastases — 1 Month

Due to (or as a consequence of):

b. Breast Cancer — 9 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: Allen Reilly MD

29c. License number: D54749

29d. Date signed (Month, Day, Year): November 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allen Reilly , M.D. 4805 Benson Avenue Baltimore, Maryland 21227

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001

32. Registrar's Signature: [signature] B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar: Amend Item #26 per Verbal G802 12/04/01 EW

Certificate of Death

Reg. No. 2001 38691

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Charles R. Whitelock, Jr.	November 13 2001	1436 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-16-7615	1 [X] M 2 [ ] F	78 Yrs.			03/21/1923	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Somerset	Princess Anne	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
30588 Pine Knoll Drive	21853	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6	none	Painter	Home Improvement

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
Charles David Whitelock	Lottie Webster

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Harold Whitelock/Son	23594 Deal Island Road, Chance, MD 21821

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Rock Creek Cemetery	11/17/2001	Chance, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
James L Hinman MO0295	Hinman Funeral Home 11673 Somerset Ave., Princess Anne, MD 21853

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Charles Whitelock Somerset #26 216-16-7615

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

26a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finet disease or condition resulting in death)	a. STROKE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	Due to (or as a consequence of): b. Hypertension	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 [ ] Yes 2 [ ] No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
C Stegman MD	D25219	11-14-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Charles D Stegman MD 30434 Mt. Vernon Rd Princess Anne, MD 21853

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 16 2001	Jenna G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#23a perPHYG802 12/04/01 EW

Certificate of Death

Reg. No. 2001 38692

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUBY LEE BRANCH WITTER

2. Date of Death: Month NOVEMBER Day 13, Year 2001

3. Time of Death: 5:30 PM

4a. Facility Name (If not institution, give street and number): CHARLES COUNTY NURSING & REHABILITATION CENTER

4b. City, Town, or Location of Death: LA PLATA

4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 577-20-0012

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV.19, 1917

9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CHARLES

10c. City, Town or Location: WALDORF

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 122 SHERMAN ROAD

10f. Zip Code: 20602

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10TH GRADE

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOSTESS

16b. Kind of Business/Industry: FOOD SERVICE

17. Father's Name (First, Middle, Last): LUTHER BRANCH

18. Mother's Name (First, Middle, Maiden Surname): LELIA SPINNER BRANCH

19a. Informant's Name/Relationship (Type, Print): EDWARD JACKSON / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 122 SHERMAN ROAD, WALDORF, MARYLAND 20602

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): FOREST HILLS CEMETERY

Date: 11/17/2001

20c. Location - City or Town, State: LYNCHBURG, VIRGINIA

21. Signature of Funeral Service Licensee: Lydia C. Thornton Johnson

LYDIA C. THORNTON JOHNSON M00583

22. Name and Address of Facility: THORNTON FUNERAL HOME, P.A.

3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640

Physician /Medical Examiner

23a. Part1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sudden Death

Due to (or as a consequence of):

b. Cardiopulmonary Arrest

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. ATRIAL FIBRILLATION

Due to (or as a consequence of):

d. DEMENTIA

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

atrial fibrillation

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Michael Leatherwood

29c. License number: D21031

29d. Date signed (Month, Day, Year): NOVEMBER 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL LEATHERWOOD - 700 OLD LINE CENTER, WALDORF, MARYLAND 20602 SUITE 210

State Registrar

31. Date filed (Month, Day, Year): NOV 15 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

EHAR/25#234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#21 per HG802 12/04/01 EW AmendItem#20a,b,c, 22/11-07-01 **Certificate of Death** Reg. No. 2001 38693

LOREN WELLS 219-44-1342

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOREN WELLS JR
2. Date of Death Month Day Year: NOVEMBER 4 2001
3. Time of Death: 0025 M
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 219-44-1342
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 54 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-22-46
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: WICOMICO
10c. City, Town or Location: SALISBURY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 405 TRINITY DRIVE APT A
10f. Zip Code: 21801
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
18b. Kind of Business/Industry: MECHANIC

17. Father's Name (First, Middle, Last): LOREN WELLS SR
18. Mother's Name (First, Middle, Maiden Surname): IRENE WELLS

19a. Informant's Name/Relationship (Type, Print): MARIE DAVIS ~ DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 609 BOOTH ST. SALISBURY, MD. 21801

20a. Method of Disposition: [X] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): ~~SPRINGHILL~~ Capital Crematory
Data: 11/9/2001
20c. Location - City or Town, State: Dover, DE ~~HEBRON, MD.~~

21. Signature of Funeral Service Licensee: ▶ Russell Fooks per DVR
22. Name and Address of Facility: Bennie Smith Funeral Home 917 W Isabella St. Salisbury, MD 21801

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Anoxic encephalopathy — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b. cardiac dysrhythmia — days
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Liva birth 2 [ ] Fatal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: End-stage Renal Failure

23a. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Cynthia Tan M.D.
29c. License number: 16725
29d. Date signed (Month, Day, Year): 11/5/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THE CONSTANTE 507-G Riverside Dr, Salisbury MD 21801

State Registrar

31. Date filed (Month, Day, Year): NOV 07 2001
32. Registrar's Signature: ▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

2DQ

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item#23a perPHYG802 12/04/01 EW
Amend #31,See#32,11/5/2001,EMW,Montg.Co.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38694

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SHIRLENE WALKER
2. Date of Death Month: 11 Day: 02 Year: 2001
3. Time of Death: 10:35 AM
4a. Facility Name *(If not institution, giva street and number)*: Springbrook Adventist Nursing & Rehab.
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 119-76-2773
6. Sax: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 45 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr 27, 1956
9. Birthplace *(State or Foreign Country)*: Jamaica

Usual Rasidance of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 8411 Navahoe Drive
10f. Zip Code: 20903
10g. Citizen of Whst Country?

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar In U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Rece - American Indian, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highast grade completed)*: Elementery/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laboratory Technician
16b. Kind of Business/Industry: Federal Government

17. Fether's Neme *(First, Middle, Last)*: Euster Walker
18. Mother's Neme *(First, Middle, Meiden Sumame)*: Victoria Elizabeth Davis

19a. Informent's Neme/Relationship *(Type, Print)*: Dellion Sitladin/ Son
19b. Mailing Address *(Street end Number or Rurel Routa Number, City or Town, State, Zip Code)*: 8411 Navahoe Drive, Silver Spring, MD 20903

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, crematory or othar piece)*: Hayes P.O. Clarendon
Data: 11/6/2001
20c. Location - City or Town, Stata: Clarendon, West Indies

21. Signeture of Funerel Service Licensee: Thomas D. Bellum
22. Neme and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilura. List only one causa on aach line.

Approximete Interval Between Onset and Death

Immediete Ceuse (Finel disease or condition resulting in death)
a. Cardiorespiratory failure.
Due to (or es e consequence of):
b. Metastatic Colon cancer
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Last
Due to (or as a consequence of):
c. Anemia,
Due to (or as a consequance of):
d. Ascites, ~~Pleural effusion~~.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only ona)*: Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Steta)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and plece, and due to the cause(s) end menner stated.

29b. Signeture and title of certifier: Babulal Das, M.D.
29c. License number: D0057952
29d. Data signed *(Month, Day, Year)*: 11/02/2001

30. Neme and address of person who completed causa of death (Item 23a) (Type, Print): Babulal Das, MD. Bowie Town Med. Practice, MD. 3060 Mitchellville Rd.

State Registrar

31. Deta filed *(Month, Day, Year)*: ~~11/02/01~~
32. Registrer's Signeture: NOV 05 2001 Geneva B. Brooks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Mont 23a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar G802 Amend Item #21 per FH 12/04/01 EW

Certificate of Death

Reg. No. 2001 38695

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Yeer	3. Time of Death
Irvin R. Waterfield	November 28 2001	10:00 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Agnes Hospital	Baltimore	None

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Dete of Birth (Month, Day, Year)	9. Birthplece (State or Foreign Country)
219 16 7978	1☒M 2☐F	77 Yrs.					Apr 7, 1924	Maryland

To Be Completed by Funeral Director

Usual Residenca of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Catonsville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
1322 Denbright Road	21228	United States

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Detes: WWII	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Service Manager	Heavy Equipment Sales & Rentals

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
Irvin R. Waterfield	Ruby M. Hobson

19e. Informent's Name/Reletionship (Type, Print)	19b. Mailing Addrese (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jeffrey R. Waterfield/Son	6630 Allview Drive Columbia, MD 21046

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, State
1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)	Lakeview Memorial Park	12-4-2001	Sykesville, MD

21. Signeture of Funeral Service Licensee	22. Name and Address of Facility
M01044 ▶ Sherri Collins-Witzke per DVR	Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximate Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in deeth)

a. Metastatic lung cancer — Approximate Intervel: 1 year

Due to (or as a consequenca of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in tha pest 12 months?	23c. If yes, outcome of pregnency	23d. Data of delivery
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal deeth 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHronic oBstructive Pulmonary disease

Diabetes Mellitus

23e. Did tobecco use contribute to the cause of death?	24a. Was an eutopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☒Probebly 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case relerred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1☒**Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner es stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
▶ Mutombo Kankonde, MD	D46704	November 28, 2001

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

MUTOMBO KANKONDE, ST AGNES HOSPITAL BALTIMORE, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 3 0 2001	▶ Barbara D Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

WATERFIELD, IRVIN R. Howard #3

NAME 6+1

CM

DHMH 17 Rev 1/2001

ORIGINAL

Amended
Items 8. & 19a. & 7.
Per FH/SC/10-31-2001
WCHD Amend Item#1 perPHYG802 12/04/01 EW

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 2001 38696

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Shirley Fisch Zink ~~Shirley Fisch ZINK~~
2. Date of Death: Month October Day 27 Year 2001
3. Time of Death: 0915
4a. Facility Name (If not institution, give street and number): 14019 Smithsburg Pike
4b. City, Town, or Location of Death: Smithsburg
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 157-10-7618
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 ~~50~~ Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 29, ~~1950~~ 1915
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Smithsburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14019 Smithsburg Pike
10f. Zip Code: 21783
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Year or Dates:
13. Was Decedant of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - American Indien, Black, Whita, atc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0-12; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired): Corp. Vice President
16b. Kind of Businass/Industry: ribbon manufacturer

17. Father's Name (First, Middle, Last): Solomon Fisch
18. Mothar's Name (First, Middle, Maiden Surname): Jessie Rechetnik

19a. Informant's Name/Ralationship (Type, Print): Mrs. Abby Lee ~~Bringmann~~ Roane -daughter
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 14019 Smithsburg Pike, Smithsburg, Maryland 21783

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cemetery, cramatory or othar place): New Montefiore Cemetery
Data: Oct. 28 2001
20c. Location - City or Town, Stata: West Babylon, New York

21. Signature of Funaral Service Licensee: James R. Spicer
22. Nama and Address of Facility: Minnich Funeral Home 415 East Wilson Blvd. Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part I. Entar the disaasa, or complications that causad tha death. Do not enter tha moda ot dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona causa on aach lina.

Approximate Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in death):
a. MYOCARDIAL INFARCTION, ACUTE — ACUTE
Dua to (or as a consequenca of):
b. ATHERO SCLEROTIC HEART DISEASE — YEARS

Sequentially list conditions, if any, leading to immedieta cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last
Dua to (or as a consequance of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceusa given in Part I.: NONE

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case rafarred to medical examinar? 1☐ Yes 2☒ No

26. Placa of Death (Check only ona): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☒ Residenca 6☐ Other (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, straet, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, death occurred at tha tima, data and placa, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, date and place, and due to the cause(s) and mennar stated.

29b. Signatura end title of certifiar: [signature], MD
29c. Licansa number: D01040
29d. Data signed (Month, Day, Year): 10-27-01

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): BARRY COHEN, MD, 322 E. ANTIETAM ST, HAGERSTOWN, MD, 21740

State Registrar

31. Data filed (Month, Day, Year): OCT 30 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

WASH-970 #1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38697

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marie Frances Andrews
2. Date of Death: Month December Day 1 Year 2001
3. Time of Death: 1:10PM M
4a. Facility Name (If not institution, give street and number): Dulaney Towson Health Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-03-5180
6. Sex: 1☐M 2☐F XX
7. Age (In yrs. last birthday): 85 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 2, 1916
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐Yes 2☐No XX
10e. Street and Number: 111 West Road
10f. Zip Code: 21204
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married XX Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes XX No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
18b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Frank Stricker
18. Mother's Name (First, Middle, Maiden Surname): Marie Hamper

19a. Informant's Name/Relationship (Type, Print): Fay A. Andrews Dtr-in-Law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1018 St Albans Road Baltimore, MD 21239

20a. Method of Disposition: 1XX Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Memorial Park
Date: 12/4/01
20c. Location - City or Town, State: Parkville, Maryland

21. Signature of Funeral Service Licensee: Dennis Stephen Kenaker
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Cerebral Vescular Accident — Approximate Interval Between Onset and Death: 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as e consequence of):
c. Due to (or as e consequence of):
d. Due to (or as e consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☑No 9☐Unknown
23c. If yes, outcome of pregnency: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☑No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Attending Physician
29c. License number: D53642
29d. Date signed (Month, Day, Year): Dec. 3 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): X/BO 21204 3007 E Northern Parkway Baltimore 21214

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature:

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#10a-f per FHG804 2/27/02 CW

Certificate of Death

Reg. No. 2001 38698

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Richard	Abbey	December 2 2001	5:20 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4883 Anchors Way	Galesville	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-52-7668	1 XX M 2 ☐ F	85 Yrs.					April 3, 1916	New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
~~MD~~ VA	FAIRFAX ~~Anne Arundel~~	~~Galesville~~ Alexandria	1 X Yes 2 ☐ ~~No~~

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1735 Belle Haven Rd ~~4883 Anchors Way~~	22307 ~~20765~~	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No 1935-71	1 ☐ Yes 2 XX No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Officer	U.S. Air Force

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Evers Abbey	Ida Mae Sargent

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Eleanor Q. Abbey (Wife)	4883 Anchors Way, Galesville, MD 20765

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Arlington National	12/13/2001	Arlington, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Barbara J Abbey	Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Interstitial Fibrosis	2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	26f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Wayne D Birbaum	D38563	December 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wayne D. Birbaum 134 Owensville Rd. West River, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	Sandra D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

#30

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38699

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DANIEL ASKEW

2. Date of Death: Month November Day 9th Year 2001

3. Time of Death: 1:10 AM

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 578-05-9731

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11/01/1910

9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: DC

10b. County:

10c. City, Town or Location: WASHINGTON

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1711 SEATON SEATON STREET NW

10f. Zip Code: 20009

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6TH

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CAR DETAILER

18b. Kind of Business/Industry: PRIVATE INDUSTRY

17. Father's Name (First, Middle, Last): GEORGE ASKEW

18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informent's Name/Relationship (Type, Print): MARIE HILLARD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4938 LAKELAND RD. COLLEGE PARK, MD 20740

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HARMONY MEM. PARK

Date: 11/15/01

20c. Location - City or Town, Stete: LANDOVER, MD

21. Signature of Funeral Service Licensee: BC Taylor

22. Name and Address of Facility: TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST. NW WASH, DC

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the moda of dying, such as cardiec or raspirato errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Finel disaase or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Pneumonia

Due to (or es e consequenca of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of deeth 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivary Month Day Year

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case relerred to medical exeminer? 1 [ ] Yes 2 [ ] No

28. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residenca 8 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 [ ] **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: , MD

29c. License number: D48006

29d. Date signed (Month, Day, Yaar): November 21st, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): KOFI BONITEY, 301 Hospital Dr., Glen Burnie, MD 21044

State Registrar

31. Date filed (Month, Day, Yeer): DEC 05 2001

32. Registrar's Signature: D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Daniel Askew

DS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38700

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Corelle Bailey-Smith
2. Date of Death Month Day Year: November 30, 2001
3. Time of Death: 955 A M
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-28-8096
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 6, 1927
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1153 N. Carey St.
10f. Zip Code: 21217
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
18b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Patrick Harding
18. Mother's Name (First, Middle, Maiden Surname): Cora Harding

19a. Informant's Name/Relationship (Type, Print): Ms. Christina Bailey (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1153 N. Carey St. Balto. Md. 21217

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion
Date: 12/10/2001
20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto, Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Myocardial infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
b. Arteriosclerotic cardiovascular disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Tracheostomy with Subcutaneous emphysema; Pulmonary atelectasis; Chronic obstructive pulmonary disease

23e. Did tobacco use contribute to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☑ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sajid Arain MD.
29c. License number: 89392
29d. Date signed (Month, Day, Year): November 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sajid Arain, M.D. c/o Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature: Geneva D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Corelle Bailey-Smith

01-6725-045

B.K.S

GEORGE S. BLAINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38701

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
GEORGE SHERMAN BLAINE	NOV. 26, 2001	1851 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ROUTE#13	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-28-8924	1 [X] M 2 [ ] F	73 Yrs.			Dec 9, 1927	Washington DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Wicomico	Salisbury	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
808 Crossbow Court	21801	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII	1 [ ] Yes 2 [X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	transport driver	hospital

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George W. Blaine	Thelma F. Harmon

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patricia Blaine/spouse	808 Crossbow Court Salisbury, MD 21801

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Ronald S. Wade, Director	State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Head INJURIES	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [X] Yes 2 [ ] No	1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
[X] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence [X] Other (Specify) AT SCENE

27. Manner of Death	26a. Date of Injury (Month, Day Year)	26b. Time of Injury	26c. Injury at Work?	26d. Describe how injury occurred
1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	11/26/01	6:05 P M	1 [ ] Yes 2 [X] No	Driver of auto involved in collision

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	26f. Location (Street and Number or Rural Route Number, City or Town, State)
Street	ROUTE #13 Salisbury, MD

29a. Certifier (Check only one) 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. M. Tips	O.C.M.E	NOV. 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACK M. TIPS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 26a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM#5 per inf/fh G802 121301 SS

Certificate of Death

Reg. No. 2001 38702

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Henri Tony Berner	November 27 2001	11:50 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Good Samaritan Nursing Center	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
~~284-38-0186~~ ~~294-03-4131~~	1☒M 2☐F	92 Yrs.			February 7, 1909	Denmark

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6637 Loch Hill Road	21239	Denmark

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Executive	Various Industries

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ferdinand Berner	Gudrun Ingeborg Schoubye

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jean Berner (wife)	6637 Loch Hill Road Baltimore, Maryland 21239

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Green Mount Crematory	11/29/2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert M. Kratz	Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, MD 21212

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	3 Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Cerebrovascular Accident	4 Months
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician**: To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Charles Hoesch	D 20390	November 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Hoesch, M.D. 5601 Loch Raven Blvd. Baltimore, Maryland 21239

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	▶ Lynda D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #10b PER FH G802 12/05/01 10d

Certificate of Death

Reg. No. 2001 38703

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mollye Berelowitz

2. Date of Death: Month 12 Day 3 Year 2001

3. Time of Death: 6:00 PM

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death: Baltimore MD

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 217-16-6406

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV.5,1921

9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: ~~N/A~~ BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: ~~1~~☒Yes 2☐No ~~XX~~

10e. Street and Number: 807 STURGIS PLACE

10f. Zip Code: 21208

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes ☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY

16b. Kind of Business/Industry: ADVERTISING

17. Father's Name (First, Middle, Last): LOUIS FRIEDMAN

18. Mother's Name (First, Middle, Maiden Surname): ROSA CAPLAN

19a. Informant's Name/Relationship (Type, Print): ALISSA B. BERELOWITZ / DAU.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 807 STURGIS PLACE - BALTIMORE, MD 21208

20a. Method of Disposition: ☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): BNAI ISRAEL CEMETERY

Date: 12/4/2001

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Severe Hypotension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coagulopathy

Due to (or as a consequence of):

c. Toxic Epidermal Necrolysis

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

Hepatic Failure

Respiratory Failure

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier: MD

29c. License number: AJ4147357

29d. Date signed (Month, Day, Year): December 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joel Klein MD Johns Hopkins Bayview 4940 Eastern Ave Baltimore MD 21224

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: D Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38704

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Minnie L. Blake
2. Date of Death Month / Day / Year: December 1 2001
3. Time of Death: 8:10 PM
4a. Facility Name *(If not institution, give street and number)*: Mercy Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 216-36-8071
6. Sex: 1☐M 2☑F
7. Age *(In yrs. last birthday)*: 90 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 7-11-11
9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑Yes 2☐No
10e. Street and Number: 937 Wilmot Ct.
10f. Zip Code: 21202
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☑Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DOMESTIC
18b. Kind of Business/Industry: DOMESTIC

17. Father's Name *(First, Middle, Last)*: Zeb Quick
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Careton

19a. Informant's Name/Relationship *(Type, Print)*: Theresa Harris (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5324 Brookway Apt 2 Columbia, MD 21044

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park
Date: 12-7-01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature] M01015
22. Name and Address of Facility: Vaughn C. Greene 4905 York Road Baltimore, MD 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Endstage Cardiomyopathy — Approximate Interval Between Onset and Death: 2 weeks
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Pulmonary Embolus — 2 weeks
Due to (or as a consequence of):
c. Deep Venous Thrombosis — 2 weeks
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other *(specify)* 9☐Unknown
23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Mobashery Medical Resident
29c. License number: P13396
29d. Date signed *(Month, Day, Year)*: December 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nilou Mobashery, M.D.
301 St. Paul Street Baltimore Maryland 21202

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 05 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38705

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Johanna Braun	December 2 2001	5:00 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
58 Johnson Road	Pasadena	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215 03 6804	1☐ M 2☒ F	81 Yrs.			Jan. 22, 1920	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Pasadena	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
58 Johnson Road	21122	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Earl Bryant	Louise Perry

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
John Braun Sr. / Son	58 Johnson Road Pasadena, Maryland 21122

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Bayview Crematory	12/4/2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Sharron Liggett	Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Hypertensive Arterio Vascular Disease	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivary
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetel deeth 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hyperlipidemia
Atrial Fibillation

23e. Did tobacco use contribute to the ceuse of death?	24a. Was an autopsy performed?	24b. Were autopsy findings availabla prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probebly 4☑ Unknown	1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☑ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D42820	12/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Christopher deBorja 3708 mountian Rd Pasadena MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38706

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Andrea Brown
2. Date of Death Month Day Year: December 3 2001
3. Time of Death: 11:15A M
4a. Facility Name (If not institution, give street and number): University of Maryland
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-44-1342
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 56 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 11, 1945
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 2420 Dorton Court
10f. Zip Code: 21230
10g. Citizen of What Country?: United States

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
18b. Kind of Business/Industry: Glove Manufacturer

17. Father's Name (First, Middle, Last): William Brown
18. Mother's Name (First, Middle, Maiden Surname): Helen Whitley

19a. Informant's Name/Relationship (Type, Print): Miss Cinderella Brown-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2420 Dorton Street, Baltimore, MD 21230

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem. Pk.
Date: Dec 8 2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensed: Calvin L. Williams
22. Name and Address of Facility: Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer: non-small cell carcinoma — 11 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Multiple brain metastases
Hypertension

23e. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No
28. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Margarita B. Jovel MD, MPH (Jovel)
29c. License number: P15768
29d. Date signed (Month, Day, Year): December 03, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Margarita B. Jovel, MD, MPH

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature: Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED 12/13/01 ITEMS#1 per phys, 10e per fh 6802 ss — Certificate of Death — Reg. No. 2001 38707

Buie, William

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William R. ~~Buie~~ Sr.

2. Date of Death (Month, Day, Year): December 1, 2001

3. Time of Death: 8:21aM

4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-09-4011

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2-26-17

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 4421 ~~Renwood~~ Wrenwood Ave

10f. Zip Code: 21212

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mail Room Supervisor

18b. Kind of Business/Industry: Bethlehem Steel

17. Father's Name (First, Middle, Last): Floyd Buie

18. Mother's Name (First, Middle, Maiden Surname): Lizzie McDougal

19a. Informant's Name/Relationship (Type, Print): William R. Buie Jr (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1429 Northgate Road Balto, MD 21218

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory — Date: 12-4-01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Peter Winfield Jacobs M01015

22. Name and Address of Facility: Vaughn C. Greene 4905 York Road Baltimore, MD 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Stroke — Approximate Interval Between Onset and Death: 5 days

Due to (or as a consequence of):
b. Ischemic cardiomyopathy — months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. End stage Renal disease — months

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D0047223

29d. Date signed (Month, Day, Year): 12.1.2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kaiser Permanente 7141 Security Blvd Baltimore MD 21244

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: D Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38708

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thelma Brithingham

2. Date of Death Month Day Year: DECEMBER 03 2001

3. Time of Death: 3:15 P.M.

4a. Facility Name (If not institution, give street and number): GENESIS ELDERCARE HAMMONDS LANE

4b. City, Town, or Location of Death: BROOKLYN PARK

4c. County of Death: ANNE ARUNDEL CO.

Funeral Director

5. Social Security Number: 212-28-4039

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 28 1910

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Anne Arundel Co.

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 904 Roberts Ave.

10f. Zip Code: 21122

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home Owner

17. Father's Name (First, Middle, Last): Albert Lopez

18. Mother's Name (First, Middle, Maiden Surname): Catherine Cross

19a. Informant's Name/Relationship (Type, Print): Nancy E. Sitskorn (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1445 Andre Street, Baltimore, Md. 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Park

Date: 12/06/2001

20c. Location - City or Town, State: Elkridge, Md.

21. Signature of Funeral Service Licensee: Thos S. Raynor

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 3204 Mountain Raod, Pasadena, Md. 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Cerebrovascular Accidents — 1yr

Due to (or as a consequence of):

b. End Stage Dementia — 2yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ramesh Sabapathy

29c. License number: D30641

29d. Date signed (Month, Day, Year): December 4 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 201-109 Back River Neck Road, Baltimore MD 21224

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38709

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): IRMA BOSLEY
2. Date of Death (Month, Day, Year): DECEMBER 1, 2001
3. Time of Death: 2:45 PM
4a. Facility Name (If not institution, give street and number): ALICE MANOR NURSING HOME
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-76-7736
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 26, 1911
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1026 ROCK HILL AVENUE
10f. Zip Code: 21229
10g. Citizen of What Country?: UNITED STATES OF AMERICA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6TH GRADE | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NEVER WORKED
16b. Kind of Business/Industry: DISABLED

17. Father's Name (First, Middle, Last): JOHN W. BOSLEY
18. Mother's Name (First, Middle, Maiden Surname): PAULINE L. ZIMMERMAN

19a. Interment's Name/Relationship (Type, Print): PATRICIA L. BROWN / GREAT NIECE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 WEST LAKE AVENUE / BALTIMORE, MARYLAND 21210

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WESTERN CEMETERY
Date: Dec. 5, 2001
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ Donald R. Watson, Jr. #M00612
22. Name and Address of Facility: ALTENBURG FUNERAL HOME, 6009 HARFORD ROAD, BALTIMORE, MARYLAND 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. mental Retardation
Due to (or as a consequence of):
b. Hydrocephalus
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Protein Calorie malnutrition
Due to (or as a consequence of):
d. Dementia

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D31464
29d. Date signed (Month, Day, Year): 12/4/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S 40A113 A. HASHMI MD, 821 N. EUTAW St 308, Balt. MD 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature: [signature] D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38710

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Naomi Florence Berlett

2. Date of Death Month Day Year: NOVEMBER 29, 2001

3. Time of Death: 3:30 AM

4a. Facility Name *(If not institution, give street and number)*: SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-66-7751

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 25, 1918

9. Birthplace *(State or Foreign Country)*: Baltimore, Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 602 Boxmere Court

10f. Zip Code: 21093

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Business Owner

16b. Kind of Business/Industry: Poultry Business

17. Father's Name *(First, Middle, Last)*: William Kellum Dietz

18. Mother's Name *(First, Middle, Maiden Surname)*: Bertha Sarah Martin

19a. Informant's Name/Relationship *(Type, Print)*: Douglas N. Norwood (Son-N-Law)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 602 Boxmere Court Timonium, Maryland 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Oak Lawn Cemetery

Date: December 3, 2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Heather Joseph Chojnacki

22. Name and Address of Facility: Lassahn Funeral Home, Inc
7401 Bel Air Road Baltimore, Maryland 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):
RECURRENT STROKE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D 37254

29d. Date signed *(Month, Day, Year)*: 11/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BOON P. LIM, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 05 2001

32. Registrar's Signature: Jeanne G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38711

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THELMA BELON

2. Date of Death Month Day Year: NOVEMBER 29, 2001

3. Time of Death: 7:20 AM

4a. Facility Name *(If not institution, give street and number)*: STELLA MARIS MERCY

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 216-58-3479

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 50 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 9/13/51

9. Birthplace *(State or Foreign Country)*: NC.

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4223 SHAMROCK AVE.

10f. Zip Code: 21206

10g. Citizen of What Country?: USA.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MAIL CLERK

16b. Kind of Business/Industry: SSA.

17. Father's Name *(First, Middle, Last)*: BEN BLACKWELL

18. Mother's Name *(First, Middle, Maiden Surname)*: MARY BLACKWELL

19a. Informant's Name/Relationship *(Type, Print)*: PARMIE GLADNEY

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6734 DOGWOOD ROAD BALTIMORE MD. 21207

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ARBUTUS MEM. PARK

Date: 12/04/01

20c. Location - City or Town, State: BALTO, MD.

21. Signature of Funeral Service Licensee: Carl A Estep

22. Name and Address of Facility: ESTEP BROTHERS FUNERAL HOME 1300 EUTAW PLACE BALTIMORE MARYLAND 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Lung Cancer — unknown.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Breast Cancer

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)* STELLA MARIS AT MERCY Hospice

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: D H Rosenberg MD

29c. License number: D40854

29d. Date signed *(Month, Day, Year)*: NOVEMBER 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl, BALTIMORE MD 21202

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 05 2001

32. Registrar's Signature: Penna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38712

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elanie Bogues

2. Date of Death Month Dey Year: Dec. 03, 2001

3. Time of Death: 7:00pm

4a. Facility Name *(If not institution, give street and number)*: Gilchrist Nursing Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 217-34-8515

6. Sex: 1☐M 2☐F XX

7. Age *(In yrs. last birthday)*: 62 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: 05-17-39

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Ellicott City

10c. City, Town or Location: Howard

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 8614 Honeysuckle Court

10f. Zip Code: 21043

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Reca - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): GED | College (1-4or 5+): NA

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clinic Coordinator

16b. Kind of Business/Industry: Kennedy Kreiger

17. Father's Nerne *(First, Middle, Last)*: Alphonso Greene, Sr.

18. Mother's Name *(First, Middle, Maiden Sumeme)*: Elizabeth White

19e. Informant's Name/Reletionship *(Type, Print)*: Sherron Bogues

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 8614 Honeysuckle Court Ellicott City, MD 21043

20e. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from Stete 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Arbutus Mem.Pk. Cem. | Date: 12-08-01 | 20c. Location - City or Town, State: Arbutus, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Fecility: Baltimore, Maryland 21202 March FH, East 1101 E. North Avenue

Physician Medical Examiner

23a. Part I. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or neart failure. List only one cause on each line.

Approximate Interval Between Onset and Deeth

Immediete Cause (Finel diseese or condition resulting in death): a. Squamous cell cancer of Lung — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last:

b. Due to (or es a consequenca of):

c. Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causes of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Wes an autopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings aveileble prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

26. Piece of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☒Other *(Specify)* Hospice

27. Manner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, streef, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: [signature], MD

29c. License number: D25205

29d. Dete signed *(Month, Dey, Year)*: December 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Dete filed *(Month, Dey, Year)*: DEC 05 2001

32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

December 3, 2001 7pm

Bogues, Elaine RR RR 12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38713

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Evelyn DeSales Barbagallo	DECEMBER 3, 2001	12:50 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FRANKLIN SQUARE HOSPITAL	ROSEDALE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-30-3550	1☐M 2☒F	90 Yrs.			July 8, 1911	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Harford	Joppa	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1008 Old Mountain Road North	21085	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William A. Haase	Nora Wynonna Hamilton

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Janet Dickhoff- Daughter	1008 Old Mountain Road North Joppa, Maryland 21085

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Parkwood Cemetery	12/7/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Heather Cain	Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS / SEPTIC SHOCK — 8 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. INFECTION, UNKNOWN ETIOLOGY

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ACUTE MYOCARDIAL INFARCTION

CARDIOMYOPATHY, POOR LEFT VENTRICULAR FUNCTION

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MOSES IZUEGBU, MD	P 15682	DECEMBER 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. MOSES IZUEGBU 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD. 21237

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

BARBAGALLO, EVELYN

RR

RR 6

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38714

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Franklin Buchholz

2. Date of Death (Month, Day, Year): December 3, 2001

3. Time of Death: 8:30 pm

4a. Facility Name (If not institution, give street and number): Genesis Eldercare Heritage Center

4b. City, Town, or Location of Death: Dundalk

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-18-2962

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 5, 1923

9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Edgemere

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5 Loring Ct Apt. F

10f. Zip Code: 21219

10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10 yrs.

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lead burner

16b. Kind of Business/Industry: Metal/Steel

17. Father's Name (First, Middle, Last): Joseph Buchholz

18. Mother's Name (First, Middle, Maiden Surname): Anna Mae

19a. Informant's Name/Relationship (Type, Print): Dorothy Buchholz

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2711 Woodsdale Ave. Baltimore Md. 21214

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory

Date: Dec. 7 2001

20c. Location - City or Town, State: Baltimore Md.

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ENDOCARDITIS

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. CHRONIC RENAL FAILURE

Due to (or as a consequence of):

d. ANEMIA

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Savinder K Jolka M.D.

29c. License number: D27188

29d. Date signed (Month, Day, Year): 12/4/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Savinder K Jolka 2 Market Place Baltimore MD 21222

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38715

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elinor Bonsall

2. Date of Death (Month, Day, Year): December 2, 2001

3. Time of Death: 12:10 pm

4e. Facility Name (If not institution, give street and number): Mariner of Glen Burnie

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 216-16-8824

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct., 21, 1922

9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1502 Charles Avenue

10f. Zip Code: 21061

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6 yrs.

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier

16b. Kind of Business/Industry: Baltimore City

17. Father's Name (First, Middle, Last): Emmitt Gressitt

18. Mother's Name (First, Middle, Maiden Surname): Clara Doering

19a. Informant's Name/Relationship (Type, Print): Cynthia Rosenberger Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1502 Charles Avenue, Glen Burnie, Md. 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Memorial Park

Date: December 6, 2001

20c. Location - City or Town, State: Parkville, Md.

21. Signature of Funeral Service Licensee: ▶ Anthony C. Connelly

22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cerdiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

Approximata Intarval Between Onset and Death

Immediate Cause (Final disease or condition resulting in daath)

a. METASTATIC BREAST CARCINOMA 1 YEAR

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequance of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was cese referred to medicei examiner? 1☐ Yes 2☒ No

26. Placa of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, daath occurred at the tima, data and place, and dua to the cause(s) and mannar statad.

29b. Signatura and title of certifier: ▶ Usha Sitaraman INTERNIST

29c. License number: D51104

29d. Date signed (Month, Day, Year): DECEMBER 3, 2001

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): USHA VEMULAKONDA 4710 PENNINGTON AVENUE, BALTIMORE MD 21226

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38716

HELEN BARANOWSKI
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
HELEN BARANOWSKI	December 1, 2001	0108 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Maryland General Hospital	Baltimore City	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-12-7760	1 M 2 F	86 Yrs.			6/21/15	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1027 CATHEDRAL ST. APT. 9C	21201	USA

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Detes:	1 Yes 2 No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	HOMEMAKER	HOME

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
FRANK VOMASTEK	VERA FUKA

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)
MISS DARLENE LANGENFELDER	17 FULLERTON HEIGHTS AVE. BALTO., MD. 21236

20e. Method of Disposition	20b. Pleca of Disposition (Name of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, State
1 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ST. STANISLAUS	12/04/01	BALTO., MD.

21. Signeture of Funerel Service Licensee: Charles Kaczorowski

22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, MD. 21222

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Enter the diseese, or complidations that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)
a. Acute Coronary Syndrome

Due to (or as e consequence of):
b. Anemia

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest

Due to (or as e consequenca of):
c. Hypertension

Due to (or as a consequence of):
d. Hypothyroidism

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Pert II. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobecco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings availeble prior to completion of cause of deeth?
1 Yes 2 No	1 Yes 2 No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Deeth	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner es steted.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
Badika, NDofunSu MD	P14571	December 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NDofunSu Badika MD, C/o Maryland General Hospital

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
DEC 05 2001	Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38717

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen P. Boyd

2. Date of Death (Month, Day, Year): November 26 2001

3. Time of Death: 4:30 P.M

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215-10-8301

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/09/15

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 4 Southfield Road

10f. Zip Code: 21060

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

18b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Vincent Tarynis

18. Mother's Name (First, Middle, Maiden Surname): Caroline Kravoczyk

19a. Informant's Name/Relationship (Type, Print): Mrs. dolores Kreglow

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 Southfield Rd. Glen Burnie, Md 21060

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Rosary cem

Date: 11/29/01

20c. Location - City or Town, State: Dundalk, Md

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Kaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, MD 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Intestinal Obstruction with rupture

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Septicemia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D43977

29d. Date signed (Month, Day, Year): November 26 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Cynthia Dorsey 301 Hospital Drive, Glen Burnie, MD 21061

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED 120501: Item#31 per DVR G802 ss

Certificate of Death

Reg. No. 2001 38718

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gail Frost CissnA

2. Data of Death — Month: Nov Day: 26 Year: 01

3. Time of Death: 8:15p

4a. Facility Name *(If not institution, give street and number)*: 5540 Etzler Road

4b. City, Town, or Location of Death: Frederick, MD

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 267-64-8225

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 61 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Jul 3 1940

9. Birthplace *(State or Foreign Country)*: FloridA

Usual Residance of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick, MD

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5540 ETZler ROAD

10f. Zip Coda: 21702

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedant's Education *(Specify only highast grada compiated)*: Elamantary/Secondary (0-12): — Collega (1-4or 5+): 4

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Newspaper Writer

16b. Kind of Businass/Industry: Media

17. Fathar's Nama *(First, Middla, Last)*: George CissnA

18. Mothar's Nama *(First, Middla, Maiden Surname)*: EleAnor Frost

19a. Informant's Name/Relationship *(Type, Print)*: HAbib MAIDANWAL

19b. Mailing Address *(Straet and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 5540 ETZIER RD. Frederick, MD 21702

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, crematory or othar place)*: METro Crematury

Data: Dec 3p

20c. Location - City or Town, Stata: Baltimore, MD

21. Signeture of Funaral Service Licensee: ▶ Ronald A Grayson

22. Nama and Address of Facility: Ronald A. GRAYSON Funeral Service 8312 Liberty Rd Baltimore, MD 21244

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiretory arrest, shock, or haart failure. List only ona cause on aach lina.

Approximate Intarval Batwaen Onset and Death

Immediata Cause (Final disaasa or condition rasulting in death)

a. Cerebral edema — 7d

Dua to (or as a consequence of):

b. Glioblastoma multiforme — 2 mo

Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disaasa or Injury that initiated avants rasulting in death) Last

Dua to (or as a consequence of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

Brain CA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to complation of causa of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residanca 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, death occurred at tha time, data and place, and dua to tha causa(s) and mannar as statad. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to tha causa(s) and mannar statad.

29b. Signatura and titla of cartifiar: ▶ [signature]

29c. Licanse number: D17C 25

29d. Data signed *(Month, Day, Year)*: Dec 5, 2001

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): 501 West 7th Street Frederick MD 21701

State Registrar

31. Data filed *(Month, Day, Year)*: ~~12/5/01~~

32. Registrar's Signature: DEC 5 2001 Jennie D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No 2001 38719

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BENJAMIN K CHENEY
2. Date of Death Month: NOV Day: 27 Year: 2001
3. Time of Death: 2047 P M
4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENGRAL HOSPITAL
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 350-09-1596
6. Sex: 1 ☐ M 2 ☐ F
7. Age (In yrs. last birthday): 92 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 29, 1911
9. Birthplace (State or Foreign Country): Russia

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 9770 Polished Stone
10f. Zip Code: 21046
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: '42-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): accounting
16b. Kind of Business/Industry: county of California

17. Father's Name (First, Middle, Last): Abraham Chernavsky
18. Mother's Name (First, Middle, Maiden Surname): Bessie Kaganove

19a. Informant's Name/Relationship (Type, Print): Kay Cheney/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9770 Polished Stone Columbia, MD 21046

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASPIRATION PNEUMONIA — 48 HRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
BULLOUS PEMPHIGUS
ATRIAL FIBRILLATION

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
26a. Date of Injury (Month, Day Year)
26b. Time of Injury M
26c. Injury at Work? 1 ☐ Yes 2 ☐ No
26d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
26f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D39629
29d. Date signed (Month, Day, Year): NOV 27, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. SYMD 10724 LITTLE PATUXENT PARKWAY COLUMBIA MD 21044

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature: Jeanine D Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38720

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
HANNAH MARIE COLE	DEC. 3, 2001	5:54 pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FUTURE CARE CANTON HARBOR	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-07-3485	1☐M 2☒F	82 Yrs.			4/13/19	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2108 BOSTON STREET	21231	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	CLERICAL	UNION TRUST BANK

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
EDWARD LYNCH	HANNAH KELLY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MRS. ELIZABETH KLINE	144 NORTH CAROLINA AVE. PASADENA, MD. 21122

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	BAYVIEW CREMATORY	12/8/01	BALTO., MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 2525 FLEET ST. BALTIMORE, MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Arteriosclerotic Heart Disease	> 2 yrs
Due to (or as a consequence of): b.	Arteriosclerosis	> 2 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Thoracic aortic aneurysm
Chronic obstructive pulmonary Disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] M. Torres M.D.	D11150	12/04/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MELITO M. TORRES, MD 441 S. ELLWOOD AVE, BALTO, MD 21224

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	[signature] D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38721

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GOLDIE L. COLES

2. Date of Death Month: NOV. Day: 30 Year: 2001

3. Time of Death: 4 00 ☒ AM ☐ PM

4a. Facility Name (If not institution, give street and number): BON SECOUR HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212 20 7415

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/20/25

9. Birthplace (State or Foreign Country): md.

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1010 W. BALTIMORE ST.

10f. Zip Code: 21223

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): WEBSTER STANLEY

18. Mother's Name (First, Middle, Maiden Surname): GRACE COOK STANLEY

19a. Informant's Name/Relationship (Type, Print): WAVERLY JENNINGS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1010 W. BALTO. ST. BALTO. MD. 21223 APT (225)

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY

Date: 12/3/01

20c. Location - City or Town, State: CATONSVILLE, MD.

21. Signature of Funeral Service Licensee: ▶C.A. ESTEP

22. Name and Address of Facility: ESTEP BROS. FUNERAL SER. P.A 1300 EUTAW PL. BALTO. MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

b. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: ▶Terance L. Lamb M.D

29c. License number: D37203

29d. Date signed (Month, Day, Year): NOV. 30 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Terance L. LAMB M.D. Bon Secours Hospital Baltimore md.

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: Rebecca D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38722

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gilbert Oliver Derrenberger

2. Date of Death Month Day Year: December 4, 2001

3. Time of Death: 12:25 AM

4a. Facility Name *(If not institution, give street and number)*: 1421 Kent Avenue

4b. City, Town, or Location of Death: Catonsville Manor

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-18-7655

8. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 14, 1925

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville Manor

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 1421 Kent Avenue

10f. Zip Code: 21207

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Police Officer

18b. Kind of Business/Industry: Law Enforcement

17. Father's Name *(First, Middle, Last)*: William George Derrenberger

18. Mother's Name *(First, Middle, Maiden Surname)*: Edna Delores Hiskey

19a. Informant's Name/Relationship *(Type, Print)*: Rita Derrenberger / spouse

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1421 Kent Avenue Baltimore, Maryland 21207

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crownsville Veteran

Date: 12/06/2001

20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: David J. Weber

22. Name and Address of Facility: David J. Weber Funeral Homes PA 5311 Edmondson Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finet disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnent at time of death 5 ☐ Other *(specify)* 9 ☐ Unknown

23d. Data of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

Obstructive sleep apnea

23e. Did tobacco use contribute to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Wes case relerred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Homa 5 ☒ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Neturet 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Couid not be determined

28a. Date of Injury *(Month, Day Yaer)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Numbar or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated. 2 ☐ **Medical Examiner:** On the besis of examination and/or investigetion, in my opinion, death occurred at tha time, date end place, end due to tha cause(s) and manner stated.

29b. Signature and title of certifier: Joseph H. Miller MD

29c. License number: D06982

29d. Date signed *(Month, Day, Year)*: 12/5/2001

30. Name and address of person who completed cause ot death (Item 23e) (Type, Print): JOSEOH H. MILLER, MD. 900 CATON AVE Baltimore Md 21229

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 05 2001

32. Registrar's Signatura: Bernice B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

17 x 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38723

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen B. Denny

2. Date of Death Month: 11 Day: 29 Year: 01

3. Time of Death: 6:15 PM

4a. Facility Name (If not institution, give street and number): 1325 Gittings Ave. (Home)

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-05-4885

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 99 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 9/21/02

9. Birthplace (State or Foreign Country): Baltimore, Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 1325 Gittings Ave.

10f. Zip Code: 21239

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

18b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Columbus Denny

18. Mother's Name (First, Middle, Maiden Surname): Sarah Denny

19a. Informant's Name/Relationship (Type, Print): Mary Jenkins

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1325 Gittings Ave, Baltimore, Md. 21239

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cem.

Date: 12/5/01

20c. Location - City or Town, State: Lansdrowns, Md.

21. Signature of Funeral Service Licensee: Lloyd M. Estep

22. Name and Address of Facility: Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Advanced dementia of Alzheimers type — 5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anemia (idiopathic bone marrow failure)

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 8☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Carla Wolf Rosenthal MD

29c. License number: D31025

29d. Date signed (Month, Day, Year): December 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Carla Wolf Rosenthal MD, 3333 N. Calvert St #325, Baltimore MD 21218

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38724

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary E. Davis
2. Date of Death (Month, Day, Year): November 30, 2001
3. Time of Death: 3:05 AM
4a. Facility Name (If not institution, give street and number): Joseph Richey Hospice
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-14-9527
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 23, 1919
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1833 Clifton Ave.
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+): 8
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic Worker
16b. Kind of Business/Industry: Private Families

17. Father's Name (First, Middle, Last): David Holt
18. Mother's Name (First, Middle, Maiden Surname): Lula Holt

19a. Informent's Name/Retationship (Type, Print): Ms. Myra Makel (niece)
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 2700 Harlem Ave. Balto. Md. 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Mt. Zion
Date: 12/6/2001
20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Nama and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock or heart failure. List only ona cause on aech line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in deeth) a.	metastatic small cell lung cancer	15 months
Due to (or as a consequence ot):		
Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributs to the causs of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☑ Other (Specify) Hospice

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signatura and title of certifier: E Tso MD
29c. Licansa number: D24170
29d. Date signed (Month, Day, Year): 30 November 2001

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print): Elizabeth Tso MD Joseph Richey Hospice 820 N. Eutaw St. Baltimore, MD 21201

State Registrar

31. Data filed (Month, Dey, Year): DEC 05 2001
32. Registrer's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

11/30/01 3:05 Am
Mary Davis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38725

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ARNETT EVANS

2. Date of Death (Month, Day, Year): Nov 30 2001

3. Time of Death: 10:16 A M

4a. Facility Name (If not institution, give street and number): University of Maryland Med Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: Unknown

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11 30 33

9. Birthplace (State or Foreign Country): Baltimore, Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: X Yes 2 ☐ No

10e. Street and Number: 1335 N. Fulton Ave.

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status: X 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Guard

18b. Kind of Business/Industry: Social Security

17. Father's Name (First, Middle, Last): Arthur J. Evans

18. Mother's Neme (First, Middle, Maiden Surname): Beatrice Evans

19e. Informant's Name/Relationship (Type, Print): Arthur Evans Brother

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1110 Poplar Grove St, Baltimore, Md. 21216

20a. Method of Disposition: X 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Garrison Forest Cem

Date: 12/6/01

20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Service Licensee: Lloyd M Step

22. Neme and Address of Facility: Estep Brothers FUneral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Massive Pulmonary Embolus — minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): b. Peripheral Vascular Disease — years

Due to (or es a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant et time of deeth 5 ☐ Other (specify) 9 ☐ Unknown

23d. Dete of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 X Probebly 4 ☐ Unknown

24e. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury el Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) end menner es stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Brian J Boscone

29c. License number: D32152

29d. Date signed (Month, Day, Year): Nov 30 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRIAN BROWNE, 22 South Greene St., Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: Geneva P Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 2058.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38726

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: NELSON L. ELLIS
2. Dete of Deeth Month Day Yeer: NOVEMBER 14, 2001
3. Time of Death: 3:30 PM
4e. Facility Neme *(If not institution, give street end number)*: 3967 Hickory Avenue
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Deeth:

Funeral Director

5. Sociel Security Number: 212-03-8418
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. lest birthdey)*: 86 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Mar 1, 1915
9. Birthplece *(Stete or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3967 Hickory Avenue
10f. Zip Code: 21211
10g. Citizen of What Country?: USA
11. Meritel Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Rece - American Indian, Bleck, White, etc. *Specify:* white
15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+): 0
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: salesperson
16b. Kind of Business/Industry: stainless steel
17. Fether's Neme *(First, Middle, Last)*: Windom A. Ellis
18. Mother's Neme *(First, Middle, Meiden Surname)*: Nettie Mary Jane Fowble
19e. Informent's Name/Relationship *(Type, Print)*: Linda Ellis/niece
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 3967 Hickory Avenue Baltimore, MD 21211
20e. Method of Disposition: 1 [ ] Burial 2 [ ] Cremetion 3 [ ] Removal from Stete 4 [ ] Donetion 5 [X] Other *(Specify)* in state
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*:
Dete:
20c. Location - City or Town, Stete:
21. Signeture of Funerel Service Licensee: Ronald S. Wade, Director
22. Neme end Address of Fecility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one cause on eech line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth)
e. MYOCARDIAL INFARCTION — MINUTES

Due to (or as e consequence of):
b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — YEARS

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: PEPTIC ULCER DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availeble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

28. Place of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*:
28b. Time of Injury: M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred:
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*:
28f. Locetion *(Street end Number or Rurel Route Number, City or Town, Stete)*:

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner**: On the besis of exemination and/or investigetion, in my opinion, death occurred et the time, date end placa, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Donald T Wuylen MD
29c. License number: D26394
29d. Dete signed *(Month, Dey, Yeer)*: 11/25/01
30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): DONALD T WUYLEN 6569 N. CHARLES St BALTO MD 21204

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: DEC 05 2001
32. Registrer's Signeture: Barbara D Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38727

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Alice		Ellerbe	November 30, 2001	12:12 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore	

Funeral Director

5. Social Security Number	6. Sex 1☐M 2☒F	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
065-36-8323		54 Yrs.			7/20/47	NY

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.		BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2719 SPELMAN ROAD APT. A2	21225	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOMEMAKER	HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JAMES WILLIAMS	GRACE WILLIAMS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
GRACE ELLERBE	2719 SPELMAN ROAD A/2 BALTO, MD. 21225

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	METRO CREMATORY	12/01/01	BALTIMORE MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Ceal A Estep	ESTEP BROTHERS FUNERAL HOME 1300 EUTAW PLACE BALTIMORE MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	3 Weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Bacteremia	3 Weeks
	c. Due to (or as a consequence of): Multi-Lobar pneumonia	3 Weeks
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute Respiratory distress Syndrome
Renal failure, Liver failure.
HUMAN Immunodeficiency Virus

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Aurum G Jacobs MD	RES 000	November 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
AURUM G JACOBS, MD 600 North Wolfe Street Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 38728

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Lisa Farrar	Nov. 22 2001	4:30 A. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
U.M.M.S. Hospital	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
042 62 2904	1☐M 2☒F	40 Yrs.			Sept. 8, 1961	Connecticut

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Bowie	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6701 Alexis Drive	20720	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Nevar Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Computer Programmer	United States Supreme Court

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Phillip Banks	Elizabeth Florence

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Robert R. Farrar Husband	6701 Alexis Drive Bowie Maryland 20720

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Rose Hill Cemetery	Nov. 30, 2001	Fayetteville, TN

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Michael L Giglio	Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Intracerebral Hemmorrhage	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Unknown Etiology	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Ryan Dan Haese, M.D.	13681	12/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Brantwood Ct. Nottingham, M.D. 21236

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	Geneva B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38729

Gleason, Kenneth

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kenneth W. Gleason Sr.

2. Date of Death (Month, Day, Year): DECEMBER 03 2001

3. Time of Death: 03:00 A M

4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-38-4455

6. Sex: [X] 1 M 2 F

7. Age (In yrs. last birthday): 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAy 16, 1941

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1201 Cord Street

10f. Zip Code: 21220

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] 1 Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: DMT Trucking

17. Father's Name (First, Middle, Last): Gordon E. Gleason

18. Mother's Name (First, Middle, Maiden Surname): MArgaret J. Stewart

19a. Informant's Name/Relationship (Type, Print): Georgeann Gleason / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1201 Cord Street Baltimore MD 21220

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HollyHillCemetery

Date: 12/6/01

20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: R. Terry Connelly

22. Name and Address of Facility: ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each lina.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Diabetes mellitus, type 2 — 20 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequenca of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal Failure

peripheral vascular disease

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Homa 5 [ ] Residanca 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred: N/A

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify): N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State): N/A

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Hanbin Li M.D

29c. Licanse number: D56531

29d. Data signed (Month, Day, Year): 12/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 6701 North Charles Street, Ste 3853, Baltimore, MD 21204

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: Jeanne D Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No: 2001 38730

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Albert Lee Giles

2. Date of Death Month Day Year: Nov. 27, 2001

3. Time of Death: 3:45 A.M

4a. Facility Name (If not institution, give street and number): Long Green Nursing Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 230-12-5821

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 20, 1920

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1735 Gorsuch Avenue

10f. Zip Code: 21218

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 8th grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Explosive Engineer

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Floyd Giles

18. Mother's Name (First, Middle, Maiden Surname): Elisa Reid

19a. Informant's Name/Relationship (Type, Print): Rebecca Mills

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1735 Gorsuch Avenue Baltimore, Md 21218

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Voshell Memorial Gardens

Date: 12/4/01

20c. Location - City or Town, State: Dundalk, Maryland

21. Signature of Funeral Service Licensee: Greg Harris

22. Name and Address of Facility: Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or hart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Fine disease or condition resulting in death)

a. Prostate carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c. Atrial Fibrillation

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

Anemia

Degenerative Joint Disease

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner slated.

29b. Signature and title of certifier

29c. License number: D 31464

29d. Date signed (Month, Day, Yeer): 11/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHOAIB A. HASHMI 821 N Eutaw St Suite 308, Balt. MD 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38731

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Gaither
2. Date of Death (Month, Day, Year): Nov. 29, 2001
3. Time of Death: 11:30pm
4a. Facility Name (If not institution, give street and number): 215 Zeppelin Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 218-10-9519
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 01-08-19
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 215 Zeppelin Avenue
10f. Zip Code: 21225
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tool Crib Attendent
16b. Kind of Business/Industry: Westinghouse Co.

17. Father's Name (First, Middle, Last): Clifton Gaither
18. Mother's Name (First, Middle, Maiden Surname): Catherine Howard

19a. Informant's Name/Relationship (Type, Print): Thelma Gaither
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 215 Zeppelin Avenue Baltimore, Maryland 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Saint Rest Cemetery
Date: 12-04-01
20c. Location - City or Town, State: Hanover, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Baltimore, Maryland 21202 March FH, East 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Lung Cancer — 5 mos
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: 031551
29d. Date signed (Month, Day, Year): November 30 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Russell R. Delucia, M.D. 3001 S. Hanover St., Baltimore, Md. 21225

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RR

RR 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #8 PER FH G802 12/05/01 JE

Certificate of Death

Reg. No. 2001 38732

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Zilphia Gillis
2. Date of Death: Month 11 Day 23 Year 01
3. Time of Death: 12:43 PM
4a. Facility Name (If not institution, give street and number): North Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 062-20-3607
6. Sex: 1 ☐ M 2 ☑ F
7. Age (In yrs. last birthday): 85 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1-13-1911
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 3163 Arundel on the Bay Rd.
10f. Zip Code: 21403
10g. Citizen of What Country? United States of America
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ukn; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Clerk
16b. Kind of Business/Industry: ukn
17. Father's Name (First, Middle, Last): Jacob Jones
18. Mother's Name (First, Middle, Maiden Surname): Mahalia
19a. Informant's Name/Relationship (Type, Print): Vincent Rowe Great-Nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2303 Calvert St. Hyattsville, MD 20783
20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lincoln Cemetery Date: 12/1/01
20c. Location - City or Town, State: Suitland, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Miller's Metropolitan Chapel 1922 Forest Dr. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	Septic Shock	8 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of): Pneumonia	8 days
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
28. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
26d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D38245
29d. Date signed (Month, Day, Year): Nov 23, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): I M Finston 600 Ridgely Ave Annapolis MD

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR 4

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38733

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DANIEL J. GORMAN SR

2. Date of Death: Month 11 Day 23 Year 2001

3. Time of Death: 0025 hrs.

4a. Facility Name (If not institution, give street and number): Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: unk

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 29, 1948

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: unk

10b. County: unk

10c. City, Town or Location: unk

10d. Inside City Limits: unk — 1 [ ] Yes 2 [ ] No

10e. Street and Number: unk

10f. Zip Code: unk

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk

16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): David Gorman

18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Reletionship (Type, Print): Virginia Denny/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1902 Tyson Landing Court McLean, VA 22102

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. End Organ Failure — Approximate Interval Between Onset and Death: Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of): Advanced liver Cirrhosis — months

c. Due to (or as a consequence of): Sepsis — week

d. Due to (or as a consequence of): Bleeding Esophageal Varices — Days

IF FEMALE:

23b. Was decedent pregnent in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnency 4 [ ] Pregnant at time of deeth 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe anemia

Alcohol Abuse

Hepatic encephalopathy

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: EFOBI, Anthony, Dmd

29c. License number: D00481144

29d. Date signed (Month, Day, Year): November 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Montgomery General Hospital, Olney MD

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Referred to M.E.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38734

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Barbara A. Gossage
2. Date of Death (Month, Day, Year): November 30 2001
3. Time of Death: 21:32
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-68-3185
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 48 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/9/52
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 718 S. ROSE STREET
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): HOWARD NICOLA
18. Mother's Name (First, Middle, Maiden Surname): MARY

19a. Informant's Name/Relationship (Type, Print): MR. CARROLL GOSSAGE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 718 S. ROSE ST. BALTIMORE, MD. 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): OAK LAWN CEMETERY
Date: 12/4/01
20c. Location - City or Town, State: BALTO., MD.

21. Signature of Funeral Service Licensee: ▶ Charles Kaczorowski
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 2525 FLEET ST. BALTIMORE, MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pancreatic Cancer	1 year
Due to (or as a consequence of): b.	Biliary Sepsis	1 week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Laryngeal Cancer
Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): November 30, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alexander Perl, MD Johns Hopkins Oncology Center, Baltimore, MD

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature: ▶ Deneise D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38735

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joan Belle Martin Hilderbrand
2. Date of Death — Month: NOV Day: 27 Year: 01
3. Time of Death: 12:00 Am
4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 166-36-2085
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug 9, 1931
9. Birthplace *(State or Foreign Country)*: Harrisburg, PA

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: ARNOLD
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 209 VIA DANTE
10f. Zip Code: 21012
10g. Citizen of Whet Country?: USA
11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)* — Elementery/Secondery (0-12): 12 — College (1-4or 5+): 4
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Regulation Writer
16b. Kind of Business/Industry: Towson Unwersity
17. Fether's Neme *(First, Middle, Last)*: Franklin Martin
18. Mother's Neme *(First, Middle, Maiden Sumeme)*: Mary Grace Ewing
19e. Informent's Neme/Reletionship *(Type, Print)*: Wilbur Hilderbrand, Sr.
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 209 VIA DANTE Arnold, MD 21012
20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Pleca of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory
Dete: Dec 7 01
20c. Location - City or Town, Stete: Baltimore, MD
21. Signeture of Funerel Service Licensee: Ronald A Grayson
22. Neme end Address of Facility: Ronald A. Grayson Funeral Service 8312 Liberty Rd. Balto, Md 21244

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on eech line. — Approximete Intervel Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in deeth)
a. Myocardial Infarction —
Due to (or es e consequence of):
b. Atherosclerosis years
Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last
Due to (or es e consequence of):
c. Diabetes Mellitus years
Due to (or es e consequence of):
d. Hyperlipidemia years

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospitel: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Day Yeer)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of exemineticn end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: James Chamberlain MD
29c. License number: D37064 MD
29d. Dete signed *(Month, Dey, Yeer)*: 11/27/01

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): James Chamberlain, MD 277 Peninsula Farm Rd, Arnold, MD 21012

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 05 2001
32. Registrar's Signeture: Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 38736

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marie H. Harden

2. Date of Death Month: November Day: 27 Year: 2001

3. Time of Death: 9:15pm

4a. Facility Name (If not institution, give street and number): Charlestown Nursing Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212 12 1144

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 24, 1919

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 709 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Mathias J. Recktenwald

18. Mother's Name (First, Middle, Maiden Surname): Marie Anna Krieg

19a. Informant's Name/Relationship (Type, Print): Stephen Sears / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 608 Luther Street Baltimore, Maryland 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Cross Cemetery

Date: 11/30/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donna M Zraniewski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES Mellitus type II

Chronic Choreform Disorder

Oropharyngeal dysphagia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Bernard F. Krajewski MD

29c. License number: D26473

29d. Date signed (Month, Day, Year): NOVEMBER 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bernard F. Krajewski, MD 711 Maiden Choice Lane, Baltimore, MD 21228

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: Barbara G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38737

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Lillian P. Harbin	November 30 2001	10:50 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Genesis Eldercare Severna Park	Severna Park	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
247 10 9678	1☐M 2☒F	93 Yrs.			Dec. 4, 1907	South Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Severna Park	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
24 Truckhouse Road	21146	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th		Clerk	Baltimore City

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas Martin Shirley	Sara M. Neal

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Shelby Humberson / Daughter	6385 Lawyers Hill Road Elkridge, Maryland 21075

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Bayview Crematory	12/5/2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Anna M Zaremsowski	Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	a. Urosepsis	5 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Alzheimer's Dementia - end stage	>2 years
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Hypothyroidism

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No 3☐Probably 4☐Unknown	1☐Yes 2☑No	1☐Yes 2☑No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☑Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
John F. Loome MD	D52788	November 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John F. Loome, M.D. 479 Jumpers Hole Road #304 Severna Park, MD 21146

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	Barbara D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #7 PER FH G802 12/05/01 JH

Certificate of Death

Reg. No. 2001 38738

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
CHARLES		HARVEY	December 2, 2001	2:47 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore City	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
207-34-3330	1☐M 2☑F	56 57 Yrs.					4-30-45	HENRY/VANHA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland		BALTIMORE	1☑Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5817 THE ALAMEDA	21239	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☑Married 3☐Widowed 4☐Divorced	1☐Yes 2☑No	1☐Yes 2☑No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	TRUCK DRIVER	TRANSPORTATION
12TH			

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumama)
CHARLES J. HARVEY Sr.	BERNICE INGRAM

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
GERTRUDE HARVEY (WIFE)	5817 THE ALAMEDA BALTIMORE, MD 21239

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	KING MEMORIAL PARK	12-7-01	BALTIMORE, MD

21. Signature of Funeral Service Licensee: [signature] MD015

22. Name and Address of Facility: VANHNG. GREENE 4905 YORK ROAD BALTO, MD 2212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. INTRACRANIAL HYPERTENSION	10 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. INTRACEREBRAL hemorrhage	10DAYS
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] MD	RES-000	12/4/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sarah B. Berman, MD; Johns Hopkins University, Department of Neurology, 600 North Wolfe St, Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Yaar)	32. Registrar's Signature
DEC 05 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38739

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FLOYD W. HOFFMAN

2. Date of Death — Month: Nov Day: 30, Year: 2001

3. Time of Death: 11:22 AM

4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 215-28-8918

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 17 1932

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2423 Washington Blvd.

10f. Zip Code: 21230

10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Glazer

16b. Kind of Business/Industry: Harbor Sales

17. Father's Name (First, Middle, Last): David M. Hoffman

18. Mother's Name (First, Middle, Maiden Surname): Margaret A. Estep

19a. Informant's Name/Relationship (Type, Print): Evelyn Hoffman (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2423 Washington Blvd. Baltimore, Md. 21230

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 12/04/2001

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CONGESTIVE HEART FAILURE	1 yr.
Due to (or as a consequence of): b.	END STAGE RENAL DISEASE	2 yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	CAD	2 yrs.
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: LUNG CARCINOMA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Hospitalist

29c. License number: W0052024

29d. Date signed (Month, Day, Year): 11/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3001 S. Hanover St., Baltimore, MD 21225 (James Welker M.D.)

State Registrar

31. Date filed (Month, Day, Year): DEC 03 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38740

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
SEAN		HARRIS	NOVEMBER 30 2001	1332 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The John Hopkins Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-86-0321	1 [X] M 2 [ ] F	37 Yrs.			SEPT. 08, 1964	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE CITY	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1236 EAST LAFAYETTE AVENUE	21202	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12TH GRADE.		PAINTER	UNEMPLOYED

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
LONNIE HARRIS	PEGGY EVANS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
TERRONDA CARR (SISTER)	3801 COLBORNE ROAD, BALTIMORE, MD. 21202

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	KING MEM. PARK	12-4-01	WOODLAWN, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Hyperkalemia	2 hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Acute Renal Failure	48 hours
	c. Due to (or as a consequence of): Pulmonary Embolis	60 hours
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	Res-000	November 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
The John Hopkins Hospital 600 North Wolfe Street Baltimore MD 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

RR

PR 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38741

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
VIOLET	E.	HAND	December 01 2001	1604 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore City	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-18-7318	1☐ M 2☒ F	79 Yrs.			4/23/22	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
641 S. BELNORD AVE.	21224	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	0	HOMEMAKER	HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
OSCAR HERFURTH	EDNA LARKIN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MR. RAYMOND A.HAND, JR.	641 S. BELNORD AVE. BALTO., MD. 21224

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	BAYVIEW CREMATORY	12/4/01	BALTO., MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Charles Kaczorowski	KACZOROWSKI FUNERAL HOME P.A. 2525 FLEET ST. BALTO., MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Breast Cancer — 10 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ M Brad Drummond, MD	RES-000	December 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
M. Brad Drummond Johns Hopkins Hospital Tower 110, Doctors Lounge 600 N. Wolfe St Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	▶ Denise D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38742

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen T. Iadevaia

2. Date of Death (Month, Day, Year): November 28 2001

3. Time of Death: 3:45 P.M.

4a. Facility Name *(If not institution, give street and number)*: Future Care – Chesapeake Center

4b. City, Town, or Location of Death: Arnold

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 219 10 4531

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 4, 1926

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Arnold

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 305 College Parkway

10f. Zip Code: 21012

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerical

16b. Kind of Business/Industry: C & P Telephone Co.

17. Father's Name *(First, Middle, Last)*: Stephan Lonczynski

18. Mother's Name *(First, Middle, Maiden Surname)*: Julianna Gasiorowski

19a. Informant's Name/Relationship *(Type, Print)*: Vince Iadevaia Jr. / Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3815 Dakota Road Hampstead, Maryland 21074

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Glen Haven Memorial Park

Date: 12/1/01

20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Donna M Baniewski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. chronic obstructive pulmonary disease — years

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D41955

29d. Date signed *(Month, Day, Year)*: 11-28-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rebecca Clamp MD 479 Jumpers Hole Rd #304 Severna Park, MD 21146

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 05 2001

32. Registrar's Signature: Penny D Sparks

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

RR

RR 2

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38743

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Florence Jones
2. Date of Death Month Day Year: December 2, 2001
3. Time of Death: 4:52 PM
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 217-38-4390
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 66 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): September 8, 1935
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Md.
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2921 Federal st
10f. Zip Code: 21232
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian
18b. Kind of Business/Industry: Public Schools Baltimore

17. Father's Name (First, Middle, Last): David Mattier
18. Mother's Name (First, Middle, Maiden Surname): Callie Rudd

19a. Informant's Name/Relationship (Type, Print): Carzenia Jones (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2010 Eastern Ave. Balto. Md. 21231

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Carmel
Date: 12-8-01
20c. Location - City or Town, State: Dundalk

21. Signature of Funeral Service Licensee: Wesley Chavis
22. Name and Address of Facility: Wesley Chavis Funeral Home 2007 Eastern Balt. Md. 21231

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cirrhosis — 3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
28. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: Res-000
29d. Date signed (Month, Day, Year): December 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sheri Chevrestsky Tejeda MD 600 North Wolfe Street Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature: P Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38744

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): STANLEY JOHNSON
2. Date of Death: Month 11 Day 30 Year 2001
3. Time of Death: 9:35 M
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-52-4323
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 51 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 8, 1950
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Lansdowne
10d. Inside City Limits: 1 ☐ Yes 2 ☑ No
10e. Street and Number: 3302 Ryerson Circle
10f. Zip Code: 21227
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
16b. Kind of Business/Industry: CAR Lot

17. Father's Name (First, Middle, Last): William Gross
18. Mother's Name (First, Middle, Maiden Surname): Consuella Johnson

19a. Informant's Name/Relationship (Type, Print): Phyllis Johnson - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3302 Ryerson Circle Lansdowne, MD 21227

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem. Pk.
Date: 12-5-01
20c. Location - City or Town, State: Arbutus, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gary P. March Funeral Home P.A. 2470 Fredrick Pass Balto., MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS
Due to (or as a consequence of): b. PNEUMONIA
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Approximate Interval Between Onset and Death:

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Pol
29c. License number: P13778
29d. Date signed (Month, Day, Year): 11/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHRISTOPHER POLK, MD 22 S GREENE ST, BALTIMORE, MD 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38745

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOUISE Ethel JONES
2. Date of Death: Month 11 Day 26 Year 01
3. Time of Death: 7:15 PM
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 227-58-9021
6. Sex: 1☐M 2☑F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11 2 13
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1☑Yes 2☐No
10e. Street and Number: 2062 Ashley Drive
10f. Zip Code: 21401
10g. Citizen of What Country? United States of America

11. Marital Status: 1☐Never Married 2☐Married 3☑Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer
16b. Kind of Business/Industry: Share Cropper

17. Father's Name (First, Middle, Last): George Roberson
18. Mother's Name (First, Middle, Maiden Surname): Lugenie —

19a. Informant's Name/Relationship (Type, Print): Theresa Jones Aunt
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2062 Ashley Dr. Annapolis, MD 21401

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bacon-Town
Date: 12/3/01
20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Miller's Metropolitan Chapel 1922 Forest Dr. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Congestive Heart failure — 48 hrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
1. Pulmonary fibrosis 2. Chronic Anemia
3. Chronic Obstructive Syndrome A St Brain tumor.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No
26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D0009453
29d. Date signed (Month, Day, Year): 11/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 1833 A Forest Dr. Ann. MD 21401

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38746

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BLANCHE JAMES

2. Date of Death Month Day Year: November 21, 2001

3. Time of Death: 12:25 AM

4a. Facility Name *(If not institution, give street and number)*: Keswick Nursing Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 213-14-9470

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct 5, 1920

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 710 W. 40th Street

10f. Zip Code: 21211

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: secretary/bookkeeper

16b. Kind of Business/Industry: unk

17. Father's Name *(First, Middle, Last)*: Samuel Charles Bowen

18. Mother's Name *(First, Middle, Maiden Surname)*: Clara Blanche Whittington

19a. Informant's Name/Relationship *(Type, Print)*: Gerald Bowen/brother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5855 Crandell Road Lothian, MD 20711

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*:

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End-stage chronic Obstructive lung disease — 20 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*:

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michelle MacGregor MD

29c. License number: D13657

29d. Date signed *(Month, Day, Year)*: November 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHELLE MacGREGOR, KESWICK, 700 W. 40th STREET, BALTIMORE, MD 21211

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 05 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38747

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CHARLES LANGLANDS KLINE
2. Date of Death (Month, Day, Year): November 11, 2001
3. Time of Death:
4a. Facility Name *(If not institution, give street and number)*: 1100 Collison Road
4b. City, Town, or Location of Death: Mayo
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 579-50-6737
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov 15, 1939
9. Birthplace *(State or Foreign Country)*: Washington DC

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Mayo
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1100 Collison Road
10f. Zip Code: 21106
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Yaar or Datas: unk
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Raca - American Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grada completed)*: Elementery/Secondery (0-12): 12 | College (1-4or 5+): 1
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: heavy equipment operator
16b. Kind of Business/Industry: construction

17. Fether's Neme *(First, Middle, Last)*: Joseph Marion Kline
18. Mother's Neme *(First, Middle, Maiden Surname)*: Dorothy Poole

19a. Informent's Neme/Relationship *(Type, Print)*: Cathern Kline/spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1100 Collison Road Mayo, MD 21106

20a. Method of Disposition: 1☐ Buriel 2☐ Cremetion 3☐ Removal from Stata 4☒ Donetion 5☐ Other *(Specify)*
20b. Plece of Disposition *(Name of cemetery, crematory or other place)*
Dete:
20c. Location - City or Town, Stata:

21. Signature of Funeral Service Licensee: ▶ Ronald S. Wade, Director
22. Name end Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Entar the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Deeth

Immediate Ceuse (Final diseese or condition resulting in deeth)
a. Coronary artery disease
Due to (or es e consequenca of):
Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseesa or injury thet initiated events resulting in deeth) Last
b. Hyperchalesterolemia
Due to (or es a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings availeble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☑ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Phyaician**: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner**: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date and pleca, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: ▶ R A Varma MD
29c. Licansa number: D0043211
29d. Data signed *(Month, Day, Year)*: 11/21/01

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): ~~Dr.~~ Rupa A Varma MD; Largo Med Ctr · 1221 Mercantile Lane Largo MD 20774

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 05 2001
32. Registrer's Signature: D Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38748

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Draza Kline

2. Date of Death Month 12 Day 02 Year 2001

3. Time of Death: 7:00 PM

4a. Facility Name *(If not institution, give street and number)*: Broadmead

4b. City, Town, or Location of Death: Cockeysville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 473-09-1594

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 24, 1909

9. Birthplace *(State or Foreign Country)*: Minnesota

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Cockeysville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13801 York Road

10f. Zip Code: 21030

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Raca - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT usa retired)*: Social Worker

16b. Kind of Business/Industry: Medical

17. Father's Name *(First, Middle, Last)*: Barney Kline

18. Mother's Name *(First, Middle, Maiden Surneme)*: Etta Goldstein

19a. Informent's Neme/Relationship *(Type, Print)*: Helen-Mary Overstreet (P.R.)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 13801 York Road Cockeysville, Maryland 21030

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, crematory or other placa)*: Green Mount Crematory | Date: 12/4/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funaral Service Licensee: Steven T. Otter

22. Name and Addrass of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Entar the disaasa, or complications that causad tha daath. Do not antar the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one ceuse on each line.

Approximate Interval Batween Onset and Death

Immediate Cause (Final disaase or condition resulting in death)
a. STROKE — 5 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest
b. HYPERTENSION

Due to (or es e consequenca of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.: Type II Diabetes mellitus

23b. Did tobacco use contributs to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and piece, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and placa, and due to the cause(s) and mannar statad.

29b. Signature and title of certifiar: Barbara Carroll MD

29c. License number: D38392

29d. Data signed *(Month, Day, Year)*: 12/3/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BARBARA CARROLL, M.D., 13801 York Rd., Cockeysville, MD

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 05 2001

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38749

KRAUSE, HELEN

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): Helen S. Krause
2. Date of Death: Month NOVEMBER, Day 27, Year 2001
3. Time of Death: 10:32 A.M.
4a. Facility Name (If not institution, give street and number): Berlin Nursing & Rehabilitation Center
4b. City, Town, or Location of Death: Berlin
4c. County of Death: Worcester
5. Social Security Number: 213 05 4029
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. — If Under 1 Year: Months, Days — If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Feb. 14, 1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Worcester
10c. City, Town or Location: Berlin
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14 Serf Place
10f. Zip Code: 21811
10g. Citizen of What Country?: U.S.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper
16b. Kind of Business/Industry: Asphalt Company
17. Father's Name (First, Middle, Last): Joseph Spiegel
18. Mother's Name (First, Middle, Maiden Surname): Amelia Tribull
19a. Informant's Name/Reletionship (Type, Print): Charles Krause Jr. / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6 Spruce Court Berlin, Maryland 21811
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Glen Haven Memorial Park
Date: 11/30/01
20c. Location - City or Town, State: Glen Burnie, Maryland
21. Signature of Funeral Service Licensee: Shannon Leggett
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Congestive heart failure
Due to (or as a consequence of):
b. Hypertension
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: atrial fibrillation, Pleural effusion

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D48221
29d. Date signed (Month, Day, Year): 11/27/01

30. Name and Address of person who completed cause of death (Item 23a) (Type, Print): DR. JULIO DEPENA — American Rehab Hlth Ctr Selbyville DE 19975

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature: [signature] B Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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RR 4

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38750

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
CLARENCE EDWARD KEARNEY JR.	November 30, 2001	0550 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Memorial Hospital	Easton	Talbot

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-26-7642	1 [X] M 2 [ ] F	70 Yrs.			Dec. 16 1930	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Anne Arundel Co.	Pasadena	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
162 Riviera Drive	21122	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Reca - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9	0	Foreman	Food Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Clarence E. Kearney Sr.	Myrtle Johnson

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Deborah M. Burdine (Daughter)	162 Riviera Drive, Pasadena, Md. 21122

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	New Cathedral Cemetery	12/03/2001	Baltimore, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Kevin E. Ecker	McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedant pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [X] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residance 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
James Sides MD	D31376	12/01/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. James Sides 920 Market Street P.O. Box 496 Denton, Md. 21629

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	B. Sparks

Clarence Kearney
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

5

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38751

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Arlene L. Lloyd
2. Date of Death (Month, Day, Year): December 2, 2001
3. Time of Death: 6:05 AM
4a. Facility Name (If not institution, give street and number): Joseph Ritchie Hospice
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-32-8332
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 4, 1937
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 4978 Clifton Ave.
10f. Zip Code: 21207
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☑ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2yrs
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): mail Handler
16b. Kind of Business/Industry: mail

17. Father's Name (First, Middle, Last): unk.
18. Mother's Name (First, Middle, Maiden Surname): Elise Butler

19a. Informant's Name/Relationship (Type, Print): Cellestine Grandy - daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6549 Woodgreen Circle Woodlawn, MD 21207

20a. Method of Disposition: 1☐ Burial 2☑ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 12-3-01
20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: ▶ Gary P. March
22. Name and Address of Facility: Gary P. March Funeral Home, P.A. 270 Fredhilton Pass Balto., MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	metastatic lung Cancer	>6 mos
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) Hospice
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ E. Tso MD
29c. License number: D24170
29d. Date signed (Month, Day, Year): December 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elizabeth Tso MD Joseph Richey Hospice 820 N. Eutaw St. Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature: ▶ [illegible] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

12/2/01 6:05 am
Arlene Lloyd
15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38752

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Albert Jerome Lowery
2. Date of Death (Month, Day, Year): December 1 2001
3. Time of Death: 5:40 PM
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 212-46-3682
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 57 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12 01 44
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6107 Robin Hill Road
10f. Zip Code: 21207
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Lever Brothers

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Martha Lowery

19a. Informant's Name/Relationship (Type, Print): Andre Lowery-Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3303 Springdale Ave, Baltimore Md 21216

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Park
Date: 12/8/01
20c. Location - City or Town, State: Arbutus, Md

21. Signature of Funeral Service Licensee: Dale March
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore, Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Sepsis — Approximate Interval Between Onset and Death: days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
advanced multiple myeloma
end stage renal disease

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

28. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated.

29b. Signature and title of certifier: Michele Henley MD
29c. License number: RES000
29d. Date signed (Month, Day, Year): December 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michele Henley MD 2401 West Belvedere Avenue Baltimore, Maryland 21215

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Patient knows Albert Jerome Lowery

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 38753

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Anna Virginia Lagon	December 2 2001	1350 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Gilchrist Center	n/a	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-03-0372	1☐ M 2☒ F	79 Yrs.			7-18-1922	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Parkville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2506 Putty Hill Avenue	21234	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Emergency Clerk	Edgewood Arsenal

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Carmen Trotta	Filomena Ruggierio

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Louis P. Trotta, C.M. Brother	Niagara University Lewiston Road Meade Hall NewYork 14109

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Sacred Heart of Jesus	12-08-2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Marie H. Zarnino	Joseph N. Zarnino Jr. Funeral Home 263 S. Conkling St. Baltimore, Maryland 21224

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. cancer: breast or lung — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) hospice

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Helen M. Gardan	D0051926	December 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Helen M. Gardan, 6565 N. Charles St. Baltimore MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	▶ Geneva B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12/2/01 1350

Lagon, Anna V.

12

01-6738-510
mnmr
Unk. 01-329
ALEXANDER S.
LOGAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38754

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
ALEXANDER S. LOGAN	November 27, 2001	2130 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2200 block of Rosalyn Avenue	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-88-9858	1 X M 2 ☐ F	26 Yrs.			12/17/74	MD.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.		BALTIMORE	1 X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
763 EAST 37th STREET	21218	USA.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12			

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ALEXANDER LOGAN SR.	EUNICE LOGAN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
APRIL BRAYBOY (freind)	763 E. 37th street Baltimore MD. 21218

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
X X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Kings Mem Park	12/04/01	Baltimore Md.

21. Signature of Funeral Service Licensee ▶ Carl U Estep

22. Name and Address of Facility Estep Brothers Funeral Home
1300 Eutaw Place Baltimore, MD. 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. GUNSHOT WOUND OF HEAD AND MULTIPLE STAB WOUNDS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as e consequence of):
c. Due to (or as a consequenca of):
d. Due to (or as a consequence of):

If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 X Yes 2 ☐ No	24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 8 X Other (Specify) at scene

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 X Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
11/27/01 FOUND	2130 FOUND M	1 ☐ Yes 2 X No	SHOT AND STABBED

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
FOUND IN VEHICLE ON STREET	2200 BLOCK OF ROSALYN AVE, BALTIMORE, MD

29a. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	O.C.M.E.	November 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARK G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	▶ Donna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38755

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nathaniel Lewis Jr.
2. Date of Death (Month, Day, Year): December 01 2001
3. Time of Death: 2355 M
4a. Facility Name (If not institution, give street and number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 298-36-5113
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 59 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 28, 1942
9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2809 Greshamway Apt. 203
10f. Zip Code: 21244
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
18b. Kind of Business/Industry: Board of Education

17. Father's Name (First, Middle, Last): Nathaniel Lewis
18. Mother's Name (First, Middle, Meiden Surname): Clemmie Garner

19a. Informant's Name/Relationship (Type, Print): Mrs. Clarice Lewis (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2809 Greshamway Apt. 203 Balto. Md. 21244

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest
Date: 12/7/2001
20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Small cell carcinoma of lung with brain and liver metastasis — Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes
Seizure disorder

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: D Roggen MD
29c. License number: D35844
29d. Date signed (Month, Day, Year): December 02 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D Roggen 5401 Old Court Rd Randallstown MD 21133

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature: G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Department of Health and Mental Hygiene.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS #24a per verbal G802 120501 ss

Certificate of Death

Reg. No. 2001 38756

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Martin Matthew McDonough

2. Date of Death (Month, Day, Year): November 24, 2001

3. Time of Death: 11:45 am

4a. Facility Name (If not institution, give street and number): Genesis Cromwell Center

4b. City, Town, or Location of Death: Parkville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-24-4510

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 5, 1930

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1300 Anglesea Street Apt. 2D

10f. Zip Code: 21224

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Not Known | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steel Worker

16b. Kind of Business/Industry: Steel Industry

17. Father's Name (First, Middle, Last): John K. McDonough, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Margaret Merryman

19a. Informant's Name/Relationship (Type, Print): Kenneth McDonough (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8026 Caradoc Drive Rosedale, Maryland 21237

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp. | Date: 11/27/2001

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Gregory E. Ruck

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. End Stage renal Disease

Due to (or as a consequence of):
b. Ischemic Heart Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Congestive heart Failure

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ziad Mirza MD CMD

29c. License number: D41901

29d. Date signed (Month, Day, Year): 11-26-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ziad Mirza, 3007 Northern Parkway, Balto, MD 21214

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: Penina D Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38757

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Diane White Miller

2. Date of Death (Month, Day, Year): DECEMBER 1, 2001

3. Time of Death: 7 16 AM

4a. Facility Name (If not institution, give street and number): Stella Maris @ Mercy Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 218-92-0671

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 33 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09-16-68

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1303 Wellsbach Way

10f. Zip Code: 21224

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade; College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales clerk

16b. Kind of Business/Industry: Clothing Store

17. Father's Name (First, Middle, Last): Donald White

18. Mother's Name (First, Middle, Maiden Surname): Carrie Brown

19a. Informant's Name/Relationship (Type, Print): Carrie White

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 602 N. Potomac Street Baltimore, Maryland 21205

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Mem. Pk. Cem.

Date: 12-06-01

20c. Location - City or Town, State: Randallstown, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: March FH, East 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Dissemenated MAI Infection	unknown
Due to (or as a consequence of):	Acquired Immuno deficiency Syndrome	unknown
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) STELLA MARIS AT MERCY HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D40854

29d. Date signed (Month, Day, Year): DECEMBER 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl BALTIMORE MD 21202

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38758

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rushimear Madison-Noble

2. Date of Death Month / Day / Year: 12 / 01 / 2001

3. Time of Death: 2035

4a. Facility Name *(If not institution, give street and number)*: Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 212-22-1550

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 02-16-27

9. Birthplace *(State or Foreign Country)*: SC

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 2035 Division Street

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12th Grade; College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Domestic

16b. Kind of Business/Industry: in home

17. Father's Name *(First, Middle, Last)*: Frank Young

18. Mother's Name *(First, Middle, Maiden Surname)*: Sarah Gladney

19a. Informant's Name/Relationship *(Type, Print)*: Sarah Cromwell

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 835 N. Central Avenue Baltimore, Maryland

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Baltimore Nat'l Cem.

Date: 12-07-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: March F.H. East 1101 E. North Ave Baltimore, Md. 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	SEVERE DEBILITATION	WEEKS
Due to (or as a consequence of): b.	BONE MARROW SUPPRESSION	3 MONTHS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	TERMINAL MULTIPLE MYELOMA	2 YEARS
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RENAL INSUFFICIENCY

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph D. Notarangelo M.D.

29c. License number: D0T316

29d. Date signed *(Month, Day, Year)*: DECEMBER 3-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH D. NOTARANGELO M.D. 301 ST. PAUL PLACE BALTIMORE MD 21202

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 05 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

RR

RR 4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38759

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Michael McCowin

2. Date of Death (Month, Day, Year): NOVEMBER 29, 2001

3. Time of Death: 11:30 PM

4a. Facility Name *(If not institution, give street and number)*: Stella Maris Hospice Care @ Mercy

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 219-74-4900A

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 41 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 05-23-60

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: ☒ 1 Yes 2 ☐ No

10e. Street and Number: 1221 E. Lanvale Street

10f. Zip Code: 21202

10g. Citizen of What Country?: USA

11. Marital Status: ☒ 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer

16b. Kind of Business/Industry: various trades

17. Father's Name *(First, Middle, Last)*: Raymond George

18. Mother's Name *(First, Middle, Maiden Surname)*: Rose McCowin

19a. Informant's Name/Relationship *(Type, Print)*: Rose Ward

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1221 E. Lanvale Street Baltimore, MD 21202

20a. Method of Disposition: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Voshell Mem. Gardens

Date: 12-07-01

20c. Location - City or Town, State: Dundalk, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Baltimore, Maryland 21202 March FH, East 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acquired Immunodeficiency Syndrome Unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. _____

Due to (or as a consequence of):

c. _____

Due to (or as a consequence of):

d. _____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: STELLA MARIS at MERCY

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)* Hospice

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D40854

29d. Date signed *(Month, Day, Year)*: NOVEMBER 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl Baltimore MD 21202

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 05 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

RR

RR 3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38760

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM NEW

2. Date of Death: Month NOVEMBER Day 24 Year 2001

3. Time of Death: 9:56 AM

4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 235-28-7931

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 12, 1927

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1300 Ellwood Street

10f. Zip Code: 21224

10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 20 years

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unk; College (1-4or 5+): unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk

16b. Kind of Business/Industry: U.S. Navy

17. Father's Name (First, Middle, Last): unk

18. Mother's Name (First, Middle, Meiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): Johns Hopkins Bayview

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4940 Eastern AVenue Baltimore, MD 21224

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other piece):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year):

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):

28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: 21050

29d. Date signed (Month, Day, Year): NOVEMBER 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. AHMED. 4940 EASTERN AVENUE. BALTIMORE MD 21224

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38761

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Mildred L. Nuse	Dec. 2, 2001	12:05am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Heritage Nursing Center	Baltimore	Baltimore

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-22-1826	1☐ M 2☒ F	92 Yrs.			May 8 1909	WestVirginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Essex	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
323 S. Taylor Ave.	21221	USA

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Cafateria Worker	School

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles F. Rice	Margaret Keener

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joseph Nuse / son	1818 Sunnyside Lane Baltimore MD 21221

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)	Holly Hill Cemetery	12/6/01	Baltimore MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ R. Terry Connelly	ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. End Stg alzheimers Dementa years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic Cardiovascular Disease
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Data signed (Month, Day, Year)
▶ M. Mancino M.D.	D08358	Dec 3 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gracito V. PATRICIO 8903 HARFORD ROAD BALTIMORE MARYLAND P. 21234.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	Deputy D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38762

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
Genevieve	Owens	12	1	01	8:45A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Health Care & Retirement Corp.	Towson, Maryland	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-24-2019	1☐M 2☒F	88 Yrs.			7/23/13	Baltimore, Md.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	N/A	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
477 OXFORD CT.	21201	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: AFRO AMERICAN

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	HOUSE KEEPER	HOTEL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ROBERT SUMMERVILLE	ELLA SUMMERVILLE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
DELEVENA BROWN	1245 GLEN EAGLE RD. BALTO. MD. 21229

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	CEDAR HILL	12/7/01	BROOKLYN, MD.

21. Signature of Funeral Service Licensee ▶ Teal A Sty

22. Name and Address of Facility: Estep Brothers Funeral SErvice, P.A. 1300 Eutaw Place, Baltimore, Md. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC BREAST CANCER	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶ [signature] MD	D53987	12-03-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KENNETH GER, M.D. 300 ARMORY PL, SUITE 4A Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
DEC 05 2001	[signature] D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38763

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Darlene Patterson			December	1	2001	2009 M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death				
Mercy	Baltimore	N/A				

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-70-7170	1☐M 2☒F	43 Yrs.					MAR.27,1958	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizan of What Country?
2031 ST.PAUL STREET	21218	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.)	14. Raca - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10TH		HOUSEKEEPER	DOMESTIC

17. Fathar's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
LEE ROYEL PATTERSON	MARY VAUGHAN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARY PATTERSON (MOTHER)	2827 E. BIDDLE STREET BALTO,MD. 21213

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MT.ZION CEMETERY	DEC.5,2001	BALTIMORE,MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Geraldine V. Scruggs	CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO,MD. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac Arrhythmia	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hypovolemia	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residenca 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledga, death occurred at tha time, data and place, and due to the cause(s) and manner as stated.
2☐**Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licansa number	29d. Data signed (Month, Day, Year)
Laura Pimentel MD	040363	December 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
301 St. Paul Pl., Baltimore, MD 21201 Dr. Laura Pimentel

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38764

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Roberts

2. Date of Death: Month 11 Day 13 Year 2001

3. Time of Death: 1215Am

4a. Facility Name (If not institution, give street and number): HCR Manor Care - Roland Park 4669 Falls Rd

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 212-18-8324

6. Sex: 1☑ M 2☐ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr 4, 1913

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4669 Falls Road

10f. Zip Code: 21209

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: '43-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): maintenance superintendent

16b. Kind of Business/Industry: Bendix Corp

17. Father's Name (First, Middle, Last): Fletcher T. Roberts

18. Mother's Name (First, Middle, Maiden Surname): Eula Rhoda Wilson

19a. Informant's Name/Relationship (Type, Print): Roberta Roberts/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 200 Cross Keys Road #30 Baltimore, MD 21210

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Progressive Decline

Due to (or as a consequence of): b. Alzheimers Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c. Psychosis

Due to (or as a consequence of): d. Protein calorie malnutrition

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Degenerative Joint Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D 31464

29d. Date signed (Month, Day, Year): 11/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S.A. Hashmi, 821 N. Eutaw St Suite 308, Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: Deanna D Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38765

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rosa Lee Robertson
2. Date of Death Month / Day / Year: December 3 2001
3. Time of Death: 4:42 PM
4a. Facility Name *(If not institution, give street and number)*: Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 229-20-5245
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: August 2 1926
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1034 Kenilworth Drive
10f. Zip Code: 21204
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Administrator
16b. Kind of Business/Industry: Nursing Home

17. Father's Name *(First, Middle, Last)*: Emmett Lee Dowdy
18. Mother's Name *(First, Middle, Maiden Surname)*: Rosa Virginia Shumaker

19a. Informant's Name/Relationship *(Type, Print)*: Janet M. Robertson (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1034 Kenilworth Drive Towson, Maryland 21204

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Carmel Pres. Ch. Cemetery
Date: 12/7/2001
20c. Location - City or Town, State: Steeles' Tavern, VA

21. Signature of Funeral Service Licensee: ▶ Steven T. Zittle
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Breast Cancer — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ W. Anthony Riley, MD
29c. License number: D25205
29d. Date signed *(Month, Day, Year)*: December 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 05 2001
32. Registrar's Signature: ▶ Sparks

DHMH 16 Rev 6/95

ORIGINAL

Rosa Lee Robertson December 03, 2001 @ 4:42 p.m.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38766

MILDRED REYNOLDS

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): MILDRED T. REYNOLDS			2. Date of Death (Month, Day, Year): December 3 2001	3. Time of Death: 6:10 P.m.
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL	4b. City, Town, or Location of Death: GLEN BURNIE	4c. County of Death: ANNE ARUNDEL CO.		
5. Social Security Number: 219-01-6167	6. Sex: 1☐ M 2☒ F	7. Age (In yrs. last birthday): 86 Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 02 1915	9. Birthplace (State or Foreign Country): Maryland			

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Anne Arundel Co.	Pasadena	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2515 229th Street	21122	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yaar or Datas:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Homemaker	Home Owner

17. Father's Nama (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Wilson	Mary Hatter

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Robert K. Hammond (Son)	629 Riverside Srive, Pasadena, Md. 21122

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)	Glen Haven Memorial Park	12/06/2001	Glen Burnie, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
M00922	McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause *on* each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive heart failure	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Ischemic cardiomyopathy	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contributa to the cause of death? 1☐ Yaa 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signatura and titla of certifier	29c. Licensa number	29d. Date signed (Month, Day, Year)
MD	D43177	December 3 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Andrew Ouzounian 301 Hospital Drive, Glen Burnie. MD 21061.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38767

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Richardson

2. Date of Death: Month Dec. Day 01 Year 2001

3. Time of Death: 240PM

4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN Hospital

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 227-20-1090

6. Sex: 1 ☑ M 2 ☐ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/14/1916

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☑ Yes 2 ☐ No

10e. Street and Number: 1200 WINDMERE Ave

10f. Zip Code: 21218

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 ☐ Yaa 2 ☑ No Specify:

14. Race - American Indian, Black, White, atc. Specify: BLACK

15. Decedent's Education (Specify only highest grada completed): Elamantary/Secondary (0-12): 6th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): CARPENTER

16b. Kind of Businass/Industry: CONSTRUCTION

17. Fathar's Nama (First, Middle, Last): WILLIE RICHARSON

18. Mothar's Nama (First, Middle, Maiden Surnama): VIRGINIA THOMAS

19a. Informant's Neme/Relationship (Type, Print): MARY NICHOLSONNE (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 4005 LOCHRAVEN BLVD BALTO, MD 21218

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify)

20b. Piece of Disposition (Nama of cematary, cramatory or othar place): MD NATIONAL Cemetery

Date: 12-6-01

20c. Location - City or Town, Stata: BALTIMORE, Maryland

21. Signature of Funeral Service Licensee: ▶ Vaughn C. Greene

22. Nema and Addrass of Facility: VAUGHN C. GREENE 4905 YORK ROAD BALTIMORE, MD 21212

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complicetions that ceusad tha daath. Do not antar tha mode ot dying, such as cerdiac or raspiratory arrest, shock, or haart failure. List only one ceusa on aach lina.

		Approximate Interval Between Onsat and Death
Immedieta Causa (Final disaesa or condition resulting in daath) a.	Pneumonia	12 hours
Dua to (or as a consequence of): b.	pulmonary aspiration	12 hours
Sequentially list conditions, if any, leading to immadiate ceusa. Entar Underlying Cause (Disease or injury that initiated evants rasulting in death) Last — Dua to (or as a consequence of): c.	stroke	2 months
d.		

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceusa given in Part I.

23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yaa 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yas 2 ☐ No

25. Was casa refarrad to medical examinar? 1 ☐ Yas 2 ☒ No

26. Place of Death (Check only ona): Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☑ Nursing Homa 5 ☐ Rasidence 6 ☐ Othar (Specify)

27. Manner of Death: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Panding Investigation 6 ☐ Could not be datarmined

28a. Deta of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and dua to tha cause(s) and mannar stated.

29b. Signalura and titla of certifiar: ▶ Jeffrey Cool MD

29c. Licensa number: D0034650

29d. Dale signed (Month, Day, Year): 12-4-01

30. Nema and addrass of parson who completed causa of daath (Item 23a) (Type, Print): 9712 Belair Rd #203, Balto, MD 21236 Jeff Cool, MD

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signatura: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar 12-6-01 JAB AMND ITM#7 PR. F.H. G802

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2001 38768 Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hamilton E. Rommal

2. Date of Death Month Day Year: 11/30/2001

3. Time of Death: 4:00AM M

4a. Facility Name (If not institution, give street and number): 11751 Franklinville Road

4b. City, Town, or Location of Death: Upper Falls

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-09-3237

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/10/1919

9. Birthplace (State or Foreign Country): Baltimore City, Md

Usual Residence of Decedent

10a. State: Md

10b. County: Baltimore

10c. City, Town or Location: Upper Falls

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 11751 Franklinville Road

10f. Zip Code: 21156

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7 years

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction

18b. Kind of Business/Industry: House Builder

17. Father's Name (First, Middle, Last): Hamilton W. Rommal

18. Mother's Name (First, Middle, Maiden Surname): Helen (unknown)

19a. Informant's Name/Relationship (Type, Print): Irma Rommal-wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11751 Franklinville Rd Upper Falls, Md 21156

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: 12/01/2001

20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: E.F. Lassahn

22. Name and Address of Facility: E.F.Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md21087

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. metastatic prostate cancer — 6 month.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

28. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D52379

29d. Date signed (Month, Day, Year): 11/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAVITHA SHIVANANDA 1124 MALE AVE BALTIMORE MD 21221

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: Sandra G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

HAMILTON ROMMAL

QB 1 of 1

RJD
BRIAN REDDING
01-6810-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38769

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Brian S. Redding

2. Date of Death (Month, Day, Year): DECEMBER 2, 2001

3. Time of Death: 0043 A.M.

4a. Facility Name *(If not institution, give street and number)*: 2300 E. FAIRMONT AVE. AND N.BRADFORD ST.

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-96-8000

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 21 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 6/30/80

9. Birthplace *(State or Foreign Country)*: Baltimore, Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 6204 Shipview Way

10f. Zip Code: 21224

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Supervise

16b. Kind of Business/Industry: Store

17. Father's Name *(First, Middle, Last)*: Herbert Stevenson

18. Mother's Name *(First, Middle, Maiden Surname)*: Edna Redding

19a. Informant's Name/Reletionship *(Type, Print)*: Edna Redding Mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1100 Bolton St, Baltimore, Maryland 21201

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Mt. Zion Cem.

Date: 12/8/01

20c. Location - City or Town, State: Lansdrown, Md.

21. Signature of Funeral Service Licensee: Lloyd M. Estep

22. Name and Address of Facility: Estep BRothers Funeral Ser, P.A. 1300 Eutaw Pl, Baltimore, Md. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Gunshot Wounds

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* (SCENE)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*: 12-2-01

28b. Time of Injury: 0039 M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how Injury occurred: subject Shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Street

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 2300 E. Fairmont Ave

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: DECEMBER 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 05 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38770

29 NOVEMBER 2001 12:30AM NANCY S. SMALLWOOD Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last): Nancy Sue Smallwood					2. Date of Death: Month November Day 29 Year 2001			3. Time of Death: 12:30 A.M.
4a. Facility Name (If not institution, give street and number): Joseph Richey House			4b. City, Town, or Location of Death: Baltimore		4c. County of Death: N/A			
5. Social Security Number: 217 74 3828	6. Sex: 1☐ M 2☒ F	7. Age (In yrs. last birthday): 42 Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year): Jan. 22, 1959			9. Birthplace (State or Foreign Country): Maryland
Usual Residence of Decedent								
10a. State: Maryland	10b. County: N/A	10c. City, Town or Location: Baltimore						10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1264 James Street			10f. Zip Code: 21223		10g. Citizen of What Country: U.S.			
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 7th / College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker			16b. Kind of Business/Industry: Own Home			
17. Father's Name (First, Middle, Last): Walter Borck					18. Mother's Name (First, Middle, Meiden Surname): Shirley Long			
19a. Informant's Name/Relationship (Type, Print): Joyce Murphy / Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4773 Mountain Road Pasadena, Maryland 21122						
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)		20b. Place of Disposition (Name of cemetery, cremetory or other piece): Cedar Hill Cemetery			Date: 12/3/01	20c. Location - City or Town, State: Baltimore, Maryland		
21. Signature of Funeral Service Licensee: Donna M Zramiowski		22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225						

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, RR

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Fine disease or condition resulting in death)	a. Cirrhosis	10 yrs
Due to (or as a consequenca of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequenca of):	
	c. Due to (or es e consequenca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) Hospice

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and pleca, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or Investigation, In my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
John W. Payne MD	D 13012	Nov 29, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W. Payne 6565 N. Charles St Baltimore, Md 21204

RR 2

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	D Sparks

DHMH 16 Rev 6/95

ORIGINAL

01-6705-510
cm
Mary Silver

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23a per ME G806 042402 ss

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 012902: ITEMS#23a, 27, 28a-f per ME G803 ss

Certificate of Death

Reg. No. 2001 38771

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Mary Silver ~~Brown~~	November 26, 2001	3:34 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sinai Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-74-5065	1☐ M 2☒ F	39 Yrs.			June 4, 1962	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2139 W. Fayette Street	21223	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2 Years	Administrator	Office of Employment Development/ State of Maryland

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Silver	Louise Miller

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Turhan Silver/ Brother	4302 Parkton St Apt. T-A Baltimore, Md 21229

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Voshell Memorial Gardens	11/30/01	Dundalk, Maryland

21. Signeture of Funeral Service Licensee	22. Name and Address of Facility
[signature]	Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ~~NARCOTIC INTOXICATION~~ NARCOTIC INTOXICATION COMPLICATING ASTHMA	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☒ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1☒ Yes 2☐ No	1☑ Yes 2☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) at scene

27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☒ ~~Could not be~~ determined	11-26-01	3:05p M	1☐ Yes 2☒ No	Unknown

X Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rurel Route Number, City or Town, State)
parking area of restaurant	The Lake Trout, 5275 Reisterstown Rd., Baltimore, MD

29a. Certifier (Check only one) 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☒ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
[signature], M.D.	O.C.M.E.	November 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
DEC 05 2001	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

01-6847-005
crn
Mary Slagle

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38772

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary M. Slagle
2. Date of Death (Month, Day, Year): December 02, 2001
3. Time of Death: 5:00 P.M.

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-48-1860
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept.13,1907
9. Birthplace (State or Foreign Country): MAryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 825 Dorsey Ave.
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 6th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): George M. Sigrist
18. Mother's Name (First, Middle, Maiden Surname): Grace Personette

19a. Informant's Name/Relationship (Type, Print): MAry M. Smith / daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5606 Plymouth Road Baltimore MD 21224

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory 12/5/01
Date:
20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: R. Terry Connelly
22. Name and Address of Facility: ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. Kirby
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): December 04, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. Kirby 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38773

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Dorothea	Cora	Serle	December	4	2001	0230 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Anne Arundel Medical Center	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
339-05-0716	1☐ M 2☒ F	84 Yrs.			Dec. 8, 1916	Illinois

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Anne Arundel	Annapolis	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
122 Great Lake Drive	21403	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Secretary	Mail Order

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Andrew Martin Nelson	Anna Ruth Brekke

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Norman H. Grinnell (Son)	122 Great Lake Drive, Annapolis, MD 21403

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Metro Crematory	12/05/2001	Baltimore, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
Hardesty Funeral Home P.A.
12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic endometrial carcinoma	6M
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

If FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	032036	12/4/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gary J. Sprague 2109 Defenbaugh Drive Chester MD 21619

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38774

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
FREDDIE	P.	SELLERS	NOV.	30	2001	11:40 AM.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4630 PARKSIDE DRIVE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
239-54-8016	1 [X] M 2 [ ] F	65 Yrs.					MAY 8, 1936	NORTH CAROLINA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE CITY	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4630 PARKSIDE DRIVE	21206	USA.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12TH GRADE		STEEL WORKER	BETHLEHEM STEEL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
MAJOR SELLERS	HARRIET LOUISE MOORE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MABEL SELLERS (WIFE)	4630 PARKSIDE DRIVE, BALTIMORE, MD 21206

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	GREATER ASHLEY CHAPEL	12-07-01	VAUGHN, NORTH CAROLINA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	1 WK
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Lymphoma	3 yrs
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

RR

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] MD	D18587	DEC 3 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAUL GORMLEY 3850 WILKENS AVE Suite 100 BALTIMORE MD 21229

RR 12

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	[signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38775

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES THOMPSON
2. Date of Death (Month, Day, Year): NOVEMBER 30 2001
3. Time of Death: 2242 M
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-18-3626
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 24, 1925
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3034 Arunah Ave.
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 4yrs
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Postal Worker
18b. Kind of Business/Industry: Post Office

17. Father's Name (First, Middle, Last): Rufus Thompson
18. Mother's Name (First, Middle, Maiden Surname): Cora Molock

19a. Informant's Name/Relationship (Type, Print): Mildred Johnson - Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4007 Barrington Rd. Balto., MD 21207

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore National
Date: 12-6-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Gary F. March
22. Name and Address of Facility: Gary F. March Funeral Home, P.A. 2410 Fredhilton Pass Balto., MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not entar the moda of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA — 5 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Christopher Dull MD
29c. License number: RES 000
29d. Date signed (Month, Day, Year): 11/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHRISTOPHER DULL Johns Hopkins BAYVIEW MEDICAL CENTER

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature: D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-6762-005
B.K.S
LARRY LEE TRAYLOR

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38776

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Larry L. Traylor
2. Date of Deeth — Month: NOV. Dey: 29, Yeer: 2001
3. Time of Death: 6:08 AM
4a. Facility Neme (If not institution, give street and number): 13 RIGHT ELEVATOR DRIVE
4b. City, Town, or Location of Death: MIDDLE RIVER
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-702940
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 45 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): August22,1956
9. Birthplace (State or Foreign Country): MAryland

Usual Residence of Decedent

10a. Stete: MD
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 13 Right Elevator Drive
10f. Zip Code: 21220
10g. Citizen of What Country?: USA

11. Meritel Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Foreman
16b. Kind of Business/Industry: Steel

17. Father's Neme (First, Middle, Last): unknown
18. Mother's Neme (First, Middle, Maiden Surneme): Ruth Pittman

19a. Informent's Name/Reletionship (Type, Print): Kimberly Richter
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 6215 Ebenezer Road Baltimore MD 21220

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Bayview Crematory Inc
Date: 12/3/01
20c. Location - City or Town, Stete: Baltimore MD

21. Signature of Funeral Service Licensee: R. Terry Connelly
22. Name end Address of Facility: ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line.

Approximete Intervel Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in deeth):
e. Contact Gunshot Wound to HEAD
Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last
b.
Due to (or es a consequence of):
c.
Due lo (or as a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.
Lung cancer

23b. Did tobacco use contribute to the causs of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was en eutopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were eutopsy findings available prior to completion of cause ot deeth? 1 ☒ Yes 2 ☐ No

25. Wes case referred to medicel exeminer? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospitel: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Manner of Deeth: 1 ☐ Neturel 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined
28e. Dete of Injury (Month, Dey Yeer): 11/29/01
28b. Time of Injury (Est): 6:00 AM
28c. Injury et Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: SUBJECT SHOT SELF
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify): residence
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete): 13 Right Elevator Drive Middle River, MD

29e. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as stated. 2 ☒ **Medicel Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier: J. M. [illegible]
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): NOV. 30, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Jack M. Titus, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Yeer): DEC 05 2001
32. Registrer's Signeture: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38777

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ann W. Titus

2. Data of Death (Month, Day, Year): December 3 2001

3. Time of Death: 3:35 P.M.

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 179 14 4115

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 14, 1918

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residance of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Odenton

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 1254 Roundtop Road

10f. Zip Coda: 21113

10g. Citizen of What Country?: U.S.

11. Marital Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yaa 2☒ No If Yas, Giva Yaer or Datea:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, apecify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 9th; College (1-4or 5+):

16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired): Prison Guard

16b. Kind of Business/Industry: Women Correction

17. Father's Nama (First, Middle, Last): George Wich

18. Mother's Nema (First, Middle, Maiden Sumama): Anna Price

19a. Informant's Name/Relationship (Type, Print): Fred Titus Sr. / Son

19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda): 1254 Roundtop Road Odenton, Maryland 21113

20a. Method of Disposition: 1☒ Buriel 2☐ Cramation 3☐ Removal from Stata 4☐ Donetion 5☐ Othar (Specify)

20b. Place of Disposition (Neme of cemetery, crametory or other place): Glen Haven Memorial Park

Data: 12/6/01

20c. Location - City or Town, Stata: Glen Burnie, Maryland

21. Signatura of Funeral Servica Licensee: Shannon Liggett

22. Nama and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar the moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on aach lina.

Approximate Intervel Batween Onsat and Death

Immediata Causa (Finel disease or condition resulting in death):

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or Injury thet initieted evants resulting in death) Last

b.

Due to (or as a consequance of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yaa 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findinga availabla prior to compiation of cause of death? 1☐ Yes 2☐ No

25. Wes casa rafarrad to medical examiner? 1☐ Yes 2☒ No

26. Placa of Death (Chack only one): Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Rasidance 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To tha best of my knowledge, death occurred at tha tima, data and place, and dua to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and mannar stated.

29b. Signatura and title of certifier: MD

29c. Licansa number: D43977

29d. Data signed (Month, Day, Year): December 3 2001.

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): Brooks Oberman 301 Hospital Drive, Glen Burnie, MD 21061.

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signatura: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

ANN TITUS

RR

RR 20

RKD

01-6789-510

JOHN

TRENT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38778

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Trent

2. Date of Death (Month, Day, Year): NOVEMBER 30, 2001

3. Time of Death: 4:58P.M.

4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 218-46-6872

6. Sex: 1☑M 2☐F

7. Age (In yrs. last birthday): 52 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 20-1949

9. Birthplace (State or Foreign Country): Balto. Maryland

Usual Residence of Decedent

10a. State: Md

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☑Yes 2☐No

10e. Street and Number: 5512 Plymouth Road

10f. Zip Code: 21214

10g. Citizen of What Country? U SA

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☑Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): Alumin Mech.

16b. Kind of Business/Industry: Home improvement

17. Father's Name (First, Middle, Last): James Trent

18. Mother's Name (First, Middle, Maiden Surname): Margert H. Williams

19a. Informant's Name/Relationship (Type, Print): Pertressia Berti Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 55 12 Plymouth Rd. Balto. md. 21214

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): V O Shell

Date: 12-8-01

20c. Location - City or Town, State: Dundalk

21. Signature of Funeral Service Licensee: Wesley Chavis Jr.

22. Name and Address of Facility: Wesley Chavis Funeral Home 2007 Eastern Ave. Baltimd. 21231

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cirhosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? partial 1☑Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☑Yes 2☐No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): DECEMBER 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #2 PER G802 12/12/01 JM

Certificate of Death

Reg. No. 2001 38779

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James A. Tunstall
2. Date of Death: Month Dec Day 02 Year 2001 (DEC 01, 2001)
3. Time of Death: 9:00 P M
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 228-26-1268
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3 9 1927
9. Birthplace (State or Foreign Country): Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6404 9th Avenue
10f. Zip Code: 20783
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Vehicle Operator
18b. Kind of Business/Industry: U S Postal Service

17. Father's Name (First, Middle, Last): James Albert Tunstall
18. Mother's Name (First, Middle, Maiden Surname): Mamie Walker

19a. Informant's Name/Relationship (Type, Print): Jacqueline T. Bynum/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4905 Cranford Terrace Upper Marlboro, MD 20772

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cheltenham Cemetery
Date: Dec 7, 2001
20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: [signature] M01188
22. Name and Address of Facility: Wells-Hawkins Funeral Svcs, PA 11300 White House Rd Upper Marlboro, MD 20774

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Massive Heart Attack

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Coronary Artery Disease
Due to (or as a consequence of):
c. Hypertension
Due to (or as a consequence of):
d. Diabetes

IF FEMALE:
23b. Was decedent pregnent in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.
Dialysis Dependent
Severe peripheral vascular disease
bilateral amputation/diabetes

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated. 2 [ ] Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D 39372
29d. Date signed (Month, Day, Year): Dec 27th 2001
30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Rashid Baghi-Nainar 344 University Blvd West Ste 324 Silver Spring, MD 20901

10

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Jac

Jacqueline

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Massive Hear

Coronary Artery Dis

Hypertension

Diabetes

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Please Type or Print in Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38780

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Fred Willard Truax

2. Data of Death Month Day Year: December 1, 2001

3. Time of Death: 12:55 AM

4a Facility Neme *(If not institution, give street end number)*: Coffman Nursing Home

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 187-16-6712

6. Sex: 1 ☒ M 2 ☐ F

7. Aga *(In yrs. last birthday)*: 83 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Year)*: March 22, 1918

9. Birthplace *(Stete or Foreign Country)*: PA

Usuel Residence of Decedent

10a. State: MD

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 1304 Pennsylvania Avenue

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Meritel Status: 1 ☐ Nevar Married 2 ☐ Merried 3 ☒ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Giva Yeer or Detes:

13. Wes Decedant of Hispanic Origin? *(Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.)*: 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter

16b. Kind of Business/Industry: Building Contractor

17. Fathar's Neme *(First, Middle, Last)*: Charles Truax

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Tenna Crouse

19e. Informent's Neme/Reletionship *(Type, Print)*: Terry Truax/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1 Hardy Court Towson, MD 21204

20e. Method of Disposition: 1 ☐ Burial 2 ☒ Cramation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Smithsburg Crematory

Date: 12/2/01

20c. Location - City or Town, Stete: Smithsburg, MD

21. Signeture of Funeral Service Licensee ▶ [signature]

22. Name end Address of Facility: Grove Funeral Home, P.A. 141 W. Main St. Hancock, MD 21750-0368

Physician /Medical Examiner

23a. Pert 1. Enter the diseesa, or complications that caused tha deeth. Do not antar the mode of dying, such as cerdiac or raspiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in deeth)

a. Atrial Fibrillation — 3 year many years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Last

b. Coronary Artery Disease

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

Dementia of Alzheimer's type

23b. Did tobacco use contributa to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings aveilable prior to completion of causa of death? 1 ☐ Yas 2 ☐ No

25. Was cese referred to medical exeminer? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Menner of Death: 1 ☐ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to tha cause(s) and manner stated.

29b. Signeture and title of certifier ▶ Edson Moody MD

29c. License number: D07857

29d. Dete signed *(Month, Day, Year)*: 12/1/01

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print): EDSON MOODY - 1190 Mt Aetna Rd, HAGERSTOWN, MD 21740

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 05 2001

32. Registrer's Signeture ▶ D Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

FRED WILLARD TRUAX

NAME KNOWN TO PHYSICIAN -

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38781

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JULIA M. TAYLOR	11/30/01	11:55P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
(HOME) 4708 FURLEY AVE.	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex 1☐M 2☒F	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220 18 7000	X	77 Yrs.			6/15/24	S.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4708 FURLEY AVE	21206	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	AFRO Specify: AMERICAN

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	1	NURSE ASSISTANT	CITY HOSPITAL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOHN H. VAUGHN	MARIE VAUGHN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BETTY HOPSON DAUGHTER	4708 FURLEY AVE. BALTO. MD. 21206

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	CEDAR HILL	12/7/01	BROOKLYN, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Cecil A Estep	ESTEP BROTHERS FUNERAL SER. P.A. 1300 EUTAW PL. BALTO. MD. 21217

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Carcinoma of breast, widely metastatic Due to (or as a consequence of):	3 1/2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

If FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia of Alzheimers type

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Carla Wolf Rosenthal MD	D31025	December 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Carla Wolf Rosenthal, MD, 3333 N. Calvert St #325, Baltimore MD 21218

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	▶

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38782

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kristine L. Vaise

2. Data of Death Month Day Year: NOVEMBER 29 2001

3. Time of Death: 605P

4a. Facility Name (If not institution, give street and number): Stella Maris at Mercy Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217 78 6560

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 41 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 2, 1959

9. Birthplace (State or Foreign Country): Massachusetts

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 4403 Prudence Street

10f. Zip Code: 21226

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Ted Pollack

18. Mother's Name (First, Middle, Maiden Surname): Alice (not available)

19a. Informant's Name/Relationship (Type, Print): Stephen Vaise / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4403 Prudence Street Baltimore, Maryland 21226

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Holy Cross Cemetery

Date: 12/3/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Jerome Framewicz

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Lung Cancer — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to compilation of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE STELLA MARIS AT MERCY

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D42854

29d. Date signed (Month, Day, Year): NOVEMBER 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl. Baltimore MD 21202

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: Bonnie P Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 16 Rev 6/95

ORIGINAL

01-6771-510
mnmr
Henry Vana

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 121001:ITEMS#23a,27 perME G802 ss

Certificate of Death

Reg. No. 2001 38783

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Henry Joseph Vana

2. Date of Death (Month, Day, Year): November 29, 2001

3. Time of Death: 2210 pm

4a. Facility Name (If not institution, give street and number): Harbor Hospital Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218 42 1087

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 28, 1946

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Linthicum

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 549 Forrest View Road

10f. Zip Code: 21090

10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Inspector

16b. Kind of Business/Industry: Electrical Inspector

17. Father's Name (First, Middle, Last): John Vana

18. Mother's Name (First, Middle, Maiden Surname): Irene Arruther

19a. Informant's Name/Relationship (Type, Print): Charlotte Vana / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 549 Forrest View Road Linthicum, Maryland 21090

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 12/4/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): November 30, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: [signature] D Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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KNOWS it's pending

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DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38784

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
DOLORES MARIE QUINN WHELAN	December 2, 2001	11:50 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
CALVERT MEMORIAL HOSPITAL	Prince Frederick	Calvert County

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-07-1189	1☐ M 2☒ F	90 Yrs.			May 17, 1911	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's Co.	Charlotte Hall	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
29431 Charlotte Hall Road	20622	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: WW2	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2 yrs	Stenographer	Insurance Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Francis Quinn	Mary Gertrude Kratzanberger

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Marion H. Chambers, Jr. (Bro-in-Law)	800 Southerly Road, # 1608, Towson, Maryland 21286

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	MD Veterans Cemetery	12/7/2001	Garrison, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Martin D. Lawson	Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration Pneumonia	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic Cardiovascular disease

Cerebrovascular Accident

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Gyan C. Surana.	D 50653	12-3-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN C. SURANA
5851 Deale Churchton Road Deale MD 20751

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	Steven D Spears

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

3

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38785

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): STEVEN EUGENE WERT
2. Data of Death Month Day Year: December 3, 2001
3. Time of Death: 3:45 A.M.
4a. Facility Name (If not institution, give street and number): 8447 Maryland Road
4b. City, Town, or Location of Death: Pasadena
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 213-46-0546
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 4 1943
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8447 Maryland Road
10f. Zip Code: 21122
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electronic Technician
16b. Kind of Business/Industry: Baltimore Gas & Electric

17. Father's Name (First, Middle, Last): Byron H. Wert
18. Mother's Name (First, Middle, Maiden Surname): Grace L. Smith

19a. Informant's Name/Relationship (Type, Print): Frances A. Wert (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8447 Maryland Road, Pasadena, Maryland 21122

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory
Date: 12/05/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. atherosclerotic heart disease — Years

Due to (or as a consequence of):
b. Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. cerebrovascular disease

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were sutopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [X] No

25. Was case refarred to medicel examinar? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifiar: [signature], MD
29c. Licansa number: D0055810
29d. Date signed (Month, Day, Year): 12/4/01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Jyothi Rao M.D. 470 D Ritchie Highway, Severna Park, Maryland 21146

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signatura: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38786

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SANDRA WITKOWSKI
2. Date of Death: Month 12 Day 03 Year 2001
3. Time of Death: 6:14 PM
4a. Facility Name (If not institution, give street and number): 2 Willow Tree Garth Apt B
4b. City, Town, or Location of Death: Cockeysville
4c. County of Death: Baltimore Co

Funeral Director

5. Social Security Number: 218-68-9024
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 46 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCTOBER 8, 1955
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE COUNTY
10c. City, Town or Location: COCKEYSVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2 WILLOW TREE GARTH APT. B
10f. Zip Code: 21030
10g. Citizen of What Country?: UNITED STATES OF AMERICA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BOOKKEEPER
16b. Kind of Business/Industry: PRIVATE BUSINESS

17. Father's Name (First, Middle, Last): HENRY DIEHL FULLER
18. Mother's Name (First, Middle, Maiden Surname): HELEN ELIZABETH MICHAEL

19a. Informant's Name/Relationship (Type, Print): TIMOTHY WITKOWSKI / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 WILLOW TREE GARTH APT. B / COCKEYSVILLE, MD. 21030

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): YORKTOWNE CREMATORY
Date: Dec. 5, 2001
20c. Location - City or Town, State: YORK, PENNSYLVANIA

21. Signature of Funeral Service Licensee: ▶ Donald R. Watson, Jr. # M00612
22. Name and Address of Facility: ALTENBURG FUNERAL HOME, 6009 HARFORD ROAD, BALTIMORE, MARYLAND 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Esophagus Cancer — 18 months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Jon Simon MD
29c. License number: D53156
29d. Date signed (Month, Day, Year): 12-4-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JON E SIMON, MD 3346 PAPER MILL ROAD PHOENIX MD 21131

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature: ▶ D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38787

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy E. Watchman

2. Date of Death: Month December Day 4 Year 2001

3. Time of Death: 6:45 a.m.

4a. Facility Name (If not institution, give street and number): Genesis Eldercare Perring Parkway

4b. City, Town, or Location of Death: Parkville

4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 213-05-0163

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 31, 1913

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3018 Christopher Avenue

10f. Zip Code: 21214

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerical

16b. Kind of Business/Industry: Office

17. Father's Name (First, Middle, Last): Roman Philip Janson

18. Mother's Name (First, Middle, Maiden Surname): Marie Cecelia Bohnet

19a. Informant's Name/Relationship (Type, Print): Antoinette Janson- Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3018 Christopher Avenue Baltimore, Maryland 21214

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Most Holy Redeemer

Date: 12/7/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Heather Cain ▶ Heather Cain

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, MD 21214

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death: days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Senile Dementia anorexia failure to thrive

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Martha Raymundo MD

29c. License number: D54518

29d. Date signed (Month, Day, Year): 12/4/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARTHA RAYMUNDO, MD 3007 E. Northern Parkway Baltimore MD 21214

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

RR

RR 6

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: ▶ D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38788

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Cecelia Mae Westmoreland

2. Date of Death Month Dey Year: Nov. 30, 2001

3. Time of Death: 4:10 PM

4a. Facility Name *(If not Institution, give street and number)*: 609 Admiral Drive Unite 106

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215-46-9925

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 54 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 31, 1947

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 609 Admiral Drive Unit 106

10f. Zip Code: 21401

10g. Citizen of What Country?: United States

11. Meritel Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 9 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Stylist/Salon Owner

16b. Kind of Business/Industry: Cosmetology

17. Father's Name *(First, Middle, Last)*: Homer Martin Westmoreland

18. Mother's Name *(First, Middle, Maiden Surname)*: Clara Jane Dickens

19a. Informent's Name/Relationship *(Type, Print)*: Victoria Dixon (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 222 Roosevelt Ave. Glen Burnie, MD 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Gardens of Faith Cemetery — Date: 12/4/2001

20c. Location - City or Town, State: Rosedale, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feiture. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Ovarian Cancer — 4yrs 6months
Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest
b.
Due to (or es a consequence of):
c.
Due to (or es a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medicef examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: Deborah K. Cundy

29c. License number: D36986

29d. Date signed *(Month, Day, Year)*: December 3, 2001

30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print): 401 N. Caroline St Baltimore MD 21231

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 05 2001

32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RR

RR 12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38789

Physician / Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY ELENA WILSON
2. Date of Death (Month, Day, Year): 11/25/01
3. Time of Death: 11:50
4a. Facility Name (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL
4b. City, Town, or Location of Death: CLINTON
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 239-38-1202
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/15/1925
9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD
10b. County: PRINCE GEORGES
10c. City, Town or Location: CAPITOL HEIGHTS
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6834 WALKERMILL RD
10f. Zip Code: 20743
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALES CLERK
16b. Kind of Business/Industry: PRIVATE

17. Father's Name (First, Middle, Last): ROOSEVELT PRIDGEN
18. Mother's Name (First, Middle, Maiden Surname): LULA JHONSON

19a. Informant's Name/Relationship (Type, Print): GERALDINE BOLDEN JOHNSON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6258 TRACI JOYCE LN., ALEXANDER, VA., 22310

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FT LINCOLN CEMETERY
Date: 11/30/01
20c. Location - City or Town, State: BRENTWOOD, MD

21. Signature of Funeral Service Licensee: B E [illegible]
22. Name and Address of Facility: TAYLOR FUNERAL HOME 1722 NORTH CAPITOL ST., NW, WASH., DC

Physician / Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction
Due to (or as a consequence of):
b. Coronary Artery Disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Colon Cancer
Diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably ☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ J. JOORIE
29c. License number: D40324
29d. Date signed (Month, Day, Year): NOVEMBER 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 7503 SURRATTS ROAD, CLINTON, MARYLAND

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38790

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Winston Wiggins Sr.

2. Date of Death: Month: November Day: 29 Year: 2001

3. Time of Death: 2:54 AM

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 243-16-4413

8. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 11, 1915

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2812 N. Loudon Ave.

10f. Zip Code: 21216

10g. Citizen of What Country?: USA

To Be Completed by Funeral Director

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Private Firm

17. Father's Name (First, Middle, Last): Cornelius Wiggins

18. Mother's Name (First, Middle, Maiden Surname): Ada Etman

19a. Informant's Name/Relationship (Type, Print): Mr. Willard Wiggins (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2812 N. Loudon Ave. Balto. Md. 21216

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Middlesex Mem. Gardens Date: 12/6/2001

20c. Location - City or Town, State: Middlesex, N.C.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: prostate cancer, hypertension

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: RES-000

29d. Date signed (Month, Day, Year): November 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Niccolo D. Della Penna, MD Sinai Hospital of Baltimore

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: D. Sparks

Patient known as Wiggins, Winston

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 1 per Dr.,G802,12/13/01dhb

Certificate of Death

Reg. No. 2001 38791

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~LILIE MAE WALKER~~ LILLY MAE WALKER
2. Date of Death: Month December Day 02 Year 2001
3. Time of Death: 9:45 a.m
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: A.A. CO.

Funeral Director

5. Social Security Number: 213 22 1923
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4/23/17
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: A.A.CO.
10c. City, Town or Location: PASADENA
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 820 WOODS ROAD
10f. Zip Code: 21122
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): GOVERNMENT WORKER
16b. Kind of Business/Industry: FT. MEADS

17. Father's Name (First, Middle, Last): JOHN H. WATTS
18. Mother's Name (First, Middle, Maiden Surname): MARY E. WATTS

19a. Informant's Name/Relationship (Type, Print): SHERMAN WATTS
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 820 WOODS RD. PASADENA, MD. 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHURCH CEM. Date: 12/8/01
20c. Location - City or Town, State: MAGOTHY, MD.

21. Signature of Funeral Service Licensee: Carl H Estep
22. Name and Address of Facility: ESTEP BROS. FUNERAL SERVICE P.A. 1300 EUTAW PL. BALTO. MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Zelete Kassahun M.D.
29c. License number: D0055973
29d. Date signed (Month, Day, Year): December 02, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Zelete Dessie 11200 Lockwood drive Silver Spring, MD 20901

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38792

Alfred Anders

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALFRED P. ANDERS
2. Date of Death (Month, Day, Year): Sept 7 2001
3. Time of Death: 2132
4a. Facility Name (If not institution, give street and number): The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 215-36-0089
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV 3 1929
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 221 TRED AVON
10f. Zip Code: 21601
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondary (0-12): 12
College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER
16b. Kind of Business/Industry: ELEMENTERY EDUCATION

17. Father's Name (First, Middle, Last): GEORGE A. ANDERS
18. Mother's Name (First, Middle, Maiden Surname): MABEL H. ERSKINE

19a. Informant's Name/Relationship (Type, Print): MARK S. ANDERS/NEPHEW
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9966 LEWISTOWN RD CORDOVA, MD 21625

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): WOODLAWN MEMORIAL PARK
Date: 9-14-01
20c. Location - City or Town, State: EASTON, MD

21. Signature of Funeral Service Licensee: ▶ JOHN R. MERCER
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. acute myocardial infarction — 15 minutes
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
hyperglycemia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Matthew Fischer, MD
29c. License number: D52251
29d. Date signed (Month, Day, Year): 9-7-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MATTHEW FISCHER M.D. 2 MARTIN COURT EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year): SEP 11 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 38793

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Anthony Arena

2. Date of Death (Month, Day, Year): November 14, 2001

3. Time of Death: 6:05 PM

4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 054-18-6679

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 23, 1923

9. Birthplace (State or Foreign Country): New York

To Be Completed by Funeral Director

Usual Residence of Decedant

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4609 Tallahassee Avenue

10f. Zip Code: 20853

10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Technical Photographer

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Frank Arena

18. Mother's Name (First, Middle, Maiden Surname): Gianni Mastrantonio

19a. Informant's Name/Relationship (Type, Print): Dorothy Maria Arena/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4609 Tallahassee Avenue, Rockville, Maryland 20853

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) Mausoleum

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery

Date: Nov. 19, 2001

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Melissa C. Yackey M01296

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular Fibrillation — Minutes

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Atherosclerotic Coronary Artery Disease — Years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thai McGreivy

29c. License number: D47093

29d. Date signed (Month, Day, Year): November 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thai McGreivy, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850

State Registrar

31. Date filed (Month, Day, Year): NOV 19 2001

32. Registrar's Signature: Benson B. Boakai

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12+1

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38794

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month / Day / Year)	3. Time of Death
IRWIN	ALTMAN	11/19/2001	8:45AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SUBURBAN HOSPITAL	BETHESDA	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
084-03-1781	1☒ M 2☐ F	91 Yrs.			07/10/1910	NEW YORK

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	MONTGOMERY	BETHESDA	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5225 POOKS HILL ROAD #713SOUTH	20814	UNITED STATES OF AMERICA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	COMMERCIAL REAL ESTATE SALES	REAL ESTATE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ELIAS ALTMAN	BERTHA SHAPIRO

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
STEPHEN ALTMAN / SON	12833 HUNTSMAN WAY, POTOMAC, MARYLAND 20854

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)	KING DAVID MEMORIAL GDNS	NOV 20, 2001	FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC BRONCHOGENIC CARCINOMA	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE,
CHRONIC ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D26571	11/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
IRVING MIZUS, MD 4930 DEL RAY AVE BETHESDA, MD 20814

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 21 2001	▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

ALTMAN, IRWIN 11/19/01 08:45AM

10

b

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38795

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wilfred Alexander Alsop
2. Date of Death (Month, Day, Year): November 16, 2001
3. Time of Death: 4:15A M
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 226-28-7571
8. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 23, 1921
9. Birthplace (State or Foreign Country): Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: DC
10b. County: N/A
10c. City, Town or Location: Washington
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 18 Bryant Street, N.W.
10f. Zip Code: 20001
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No
If Yes, Give Year or Dates: 1943-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc.
Specify: African American

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Entrepreneur
16b. Kind of Business/Industry: Gas Stations

17. Father's Name (First, Middle, Last): Simon Lee Alsop
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Anna Ford

19a. Informant's Name/Relationship (Type, Print): Daisy Lee McKelly Alsop/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18 Bryant Street, N.W. Washington, D.C. 20001

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
Date: 11/21/01
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: Joanna E. Ellsberry
22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Washington, D.C. 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	SEPSIS	~ 2 dys
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): b.	RESPIRATORY FAILURE	~ "
Due to (or as a consequence of): c.	RENAL FAILURE	~ "
Due to (or as a consequence of): d.		

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)
Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Sawyer
29c. Licanse number: D-17874
29d. Date signed (Month, Day, Year): 11-16-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SANKARAN M. NAYAR, MD 3717-38TH ST COTTAGE CITY, MD 20722

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001
32. Registrar's Signature: G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38796

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CORINNE ADLER

2. Date of Death (Month, Day, Year): NOVEMBER 18, 2001

3. Time of Death: 8:05 PM.

4a. Facility Name (If not institution, give street and number): REBECCA HOUSE ASSISTED LIVING

4b. City, Town, or Location of Death: POTOMAC

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 055-10-6089

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAR. 25, 1917

9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: BETHESDA

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6719 SELKIRK DRIVE

10f. Zip Code: 20817

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): INTERIOR DECORATOR

16b. Kind of Business/Industry: INTERIOR DECORATOR

17. Father's Name (First, Middle, Last): HENRY SAMEK

18. Mother's Name (First, Middle, Maiden Surname): BERT STEINER

19a. Informant's Name/Relationship (Type, Print): ARTHUR A. ADLER, JR. - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6719 SELKIRK DR., BETHESDA, MD. 20817

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): WASHINGTON HEBREW CONG.

Date: 11/21/01

20c. Location - City or Town, State: WASHINGTON, D.C.

21. Signature of Funeral Service Licensee: Nancy A. Percantie

22. Name and Address of Facility: JOSEPH GAWLER'S SONS, INC. 5130 WISC. AVE. NW., WASHINGTON, D.C. 20016

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. DYSPHAGIA — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ALZHEIMER'S DISEASE — YEARS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PACEMAKER, HYPERLIPIDEMIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) ASSISTED LIVING

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) end manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D35579

29d. Date signed (Month, Day, Year): NOVEMBER 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUSAN J. MILLER, MD. 6844 TULIP TERR., BETHESDA, MARYLAND 20816

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001

32. Registrar's Signature: Geneva B. Sparks

ORIGINAL

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38797

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AUDREY MAE BAYLY

2. Date of Death (Month, Day, Year): SEPTEMBER 28, 2001

3. Time of Death: 6:15 AM

4a. Facility Name (If not institution, give street and number): TALBOT HOSPICE HOUSE

4b. City, Town, or Location of Death: EASTON

4c. County of Death: TALBOT

Funeral Director

5. Social Security Number: 198-03-7238

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APR 30, 1919

9. Birthplace (State or Foreign Country): CANADA

Usual Residence of Decedent

10a. State: MD

10b. County: TALBOT

10c. City, Town or Location: EASTON

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 112 PARK LANE

10f. Zip Code: 21601

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PHYSICAL THERAPIST ASSISTANT

16b. Kind of Business/Industry: HEALTHCARE

17. Father's Name (First, Middle, Last): WILLIAM QUINTRELL

18. Mother's Name (First, Middle, Maiden Surname): JESSIE IRENE BOMBAY

19a. Informant's Name/Relationship (Type, Print): EILEEN G. GEBHART/NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13712 PARAISO RD., OCEAN SPRINGS, MS 39564

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MD VETERANS CEMETERY

Date: 10-2-01

20c. Location - City or Town, State: HURLOCK, MD

21. Signature of Funeral Service Licensee: JOHN R. MERCER

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. pulmonary fibrosis — Due to (or as a consequence of): — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHF

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify): HOSPICE HOUSE

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D25750

29d. Date signed (Month, Day, Year): 9-28-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. ROBERT B. SANCHEZ M.D. 508 IDLEWILD AVE EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year): OCT 01 2001

32. Registrar's Signature: Edward A. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38798

Evelyn Brown

SBB.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVELYN TROLINGER BROWN
2. Date of Death (Month, Day, Year): Nov. 17, 2001
3. Time of Death: 0130 M
4a. Facility Name (If not institution, give street and number): Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 220-30-0156
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 71 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 24, 1929
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Talbot
10c. City, Town or Location: St. Michaels
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 605 Landing Rd.
10f. Zip Code: 21663
10g. Citizen of Whet Country?: U.S.A,
11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Housewife
18b. Kind of Business/Industry: Home
17. Father's Name (First, Middle, Last): William P. Trolinger
18. Mother's Name (First, Middle, Maiden Surname): Katherine White
19e. Informant's Name/Relationship (Type, Print): Jay P.W. Brown Jr. Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 21 Royal Oak Maryland 21662
20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Pleca of Disposition (Name of cemetery, crematory or other place): Capitol Crematory
Dete: 11-19-2001
20c. Location - City or Town, State: Dover, Delaware
21. Signature of Funeral Service Licensee: Harrison E. Leonard
22. Name and Address of Facility: Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. INTRACEREBRAL BLEED — 6 DAYS

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or es e consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnency: 1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant et time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ACUTE MYOCARDIAC INFARCTION

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐Yes 2☒No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as steted. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. Licanse number: D0053815
29d. Date signed (Month, Day, Year): 11/19/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Korah Pulimood M.D. 510 S. 5th Ave Denton, Maryland 21629

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001
32. Registrar's Signature: Donna D. Sparks

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38799

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Mary Magdalene Bramell	November 18, 2001	10:00A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Genesis ElderCare Center	LaPlata	Charles

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-09-0904	1☐M 2☒F XX	87 Yrs.			10-07-1914	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Charles	Indian Head	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
156 Circle Avenue	20640	United States

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Homemaker	Her Home

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surname)
John Thaddeus Riley	Alice Virginia Weeks

19a. Informant's Name/Relationship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Jean Alice Artes/Daughter	4845 Abell Lane, Indian Head, Maryland 20640

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☒Burial 2☐Cremetion 3☐Removel from State 4☐Donation 5☐Other (Specify) Maryland	Veterans Cemetery	11-21-2001	Cheltenham, Maryland

21. Signature of Funeral Service Licensee	22. Name end Address of Facility
▶ M00668	Williams Funeral Home 20640 4270 Hawthorne Road, Indian Head, Maryland

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or heart faiture. List only one cause on each line.

Approximata Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Carcinoma of breast

Due to (or es a consequence of):

c.

Due to (or as e consequence of):

d.

tF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnency	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant at time of deeth 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probebly 4☒Unknown

24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) and mennar es steted.

2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D45737	11/20/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. N Gurusamy, M.D. 6 Post Office Rd., Waldorf, Maryland 20603

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 26 2001	Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38800

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CARLTON WOODROW BUSSELLS
2. Date of Death: Month Nov. Day 17, Year 2001
3. Time of Death: 5PM
4a. Facility Name (If not institution, give street and number): SALISBURY REHAB & NURSING CENTER
4b. City, Town, or Location of Death: SALISBURY, M.D.
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 213-24-2060
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): May 29,1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3549 St. Lukes Road
10f. Zip Code: 21804
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+): --
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer
16b. Kind of Business/Industry: Farming

17. Father's Name (First, Middle, Last): Carlton Lesley Bussells
18. Mother's Name (First, Middle, Maiden Surname): Ethel M. Pollitt

19a. Informant's Name/Relationship (Type, Print): Katharyn H. Bussells/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3549 St. Lukes Rd., Salisbury, MD 21804

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Wicomico Memorial Park
Date: 11/21/01
20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: David H. Bowers MD1051
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Tuberculosis	weeks
Due to (or as a consequence of): b.	cerebral emboli	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	congestive heart failure	years
d.	atrial fibrillation	years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: 025549
29d. Date signed (Month, Day, Year): 11-19-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM ROBINS, M.D.,1104 HEALTHWAY DR.,SALISBURY, MD. 21804

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

BUSSELLS, CARLTON

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38801

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Katie Mae Briddell

2. Date of Death (Month, Day, Year): November 16, 2001

3. Time of Death: 1315

4a. Facility Name *(If not institution, give street and number)*: Atlantic General Hospital

4b. City, Town, or Location of Death: Berlin

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 214-34-5776

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 23, 1937

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Bishopville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 11915 Campbelltown Rd.

10f. Zip Code: 21813

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Bus Contractor

16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: James Walters

18. Mother's Name *(First, Middle, Maiden Surname)*: Gertrude Tingle

19a. Informant's Name/Relationship *(Type, Print)*: Richard M. Briddell, Sr./husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11915 Campbelltown Rd., Bishopville, MD 21813

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Curtis UMC Cemetery

Date: 11/21/01

20c. Location - City or Town, State: Bishopville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Lewis N. Watson Funeral Home, 1618 West Rd., Salisbury, MD 21801

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. pulmonary emboli — 1 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: metastatic colon cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Physician

29c. License number: H44283

29d. Date signed *(Month, Day, Year)*: 11/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Durkin, 9733 Healthway Drive, Berlin, MD

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 19 2001

32. Registrar's Signature: Janice G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2001 38802

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDNA BOZMAN
2. Date of Death: Month 11 Day 14 Year 2001
3. Time of Death: 0325
4a. Facility Name (If not Institution, give street and number): WATERVIEW HEALTHCARE CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 215-58-7376
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9/27/1906
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Somerset
10c. City, Town or Location: Upper Fairmont
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: Bozman Road
10f. Zip Code: 21867
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Rufus Woodell
18. Mother's Name (First, Middle, Maiden Surname): Deborah Lynn Lowry

19a. Interment's Name/Relationship (Type, Print): Christine Smith/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27761 Cross Creek Dr., Salisbury, MD 21801

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Beechwood Cemetery
Date: 11/16/01
20c. Location - City or Town, State: Princess Anne, MD

21. Signature of Funeral Service Licensee: David M. Thompson M01051
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DEMENTIA
CVA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Mahesh Moondra
29c. License number: D32014
29d. Date signed (Month, Day, Year): 11/15/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MAHESH MOONDRA MD 106 Milford St 504 B Salisbury MD 21804

State Registrar

31. Date filed (Month, Day, Year): NOV 16 2001
32. Registrar's Signature: Glenda G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4 DQ

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ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38803

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HAROLD DENTON BROCKWELL
2. Date of Death (Month, Day, Year): NOVEMBER 25, 2001
3. Time of Death: 6:15 PM
4a. Facility Name (If not institution, give street and number): Genesis Eldercare
4b. City, Town, or Location of Death: La Plata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 578-09-5296
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC 1, 1912
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2656 Upbrook Court
10f. Zip Code: 20602
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Printer
16b. Kind of Business/Industry: US Government

17. Father's Name (First, Middle, Last): Asa Brockwell
18. Mother's Name (First, Middle, Maiden Surname): Lottie Avery Brockwell

19a. Informent's Name/Relationship (Type, Print): Eileen L. George (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2656 Upbrook Court Waldorf, MD 20602

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 11-26-01
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: John H Eberwein M00173
22. Name and Address of Facility: Eberwein Funeral Services 4433 White Pls. La. White Pls., MD 20695

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
e. Chronic obstructive pulmonary disease

Due to (or as a consequence of):
b. atherosclerotic cardiovascular disease

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last

Due to (or es e consequence of):
c.

Due fo (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [X] **Yes** 2 [ ] **No** 3 [ ] **Probably** 4 [ ] **Unknown**

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to *medical* examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D0022574
29d. Date signed (Month, Day, Year): 11/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 12070 Old Line Center Waldorf MD 20603

State Registrar

31. Date filed (Month, Day, Year): NOV 27 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38804

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HERMAN ALFRED BOOG
2. Date of Death (Month, Day, Year): NOVEMBER 15, 2001
3. Time of Death: 2:10PM
4a. Facility Name *(If not institution, give street and number)*: 4135 ELLIOTT ISLAND ROAD
4b. City, Town, or Location of Death: VIENNA
4c. County of Death: DORCHESTER

Funeral Director

5. Social Security Number: 215-36-2447
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JUNE 18, 1925
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: DORCHESTER
10c. City, Town or Location: VIENNA
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4135 ELLIOTT ISLAND ROAD
10f. Zip Code: 21869
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: FARMER
16b. Kind of Business/Industry: GRAIN

17. Father's Name *(First, Middle, Last)*: FREDERICK ANTONE BOOG
18. Mother's Name *(First, Middle, Maiden Surname)*: LAVADA ESTELLE HACKETT

19a. Informant's Name/Relationship *(Type, Print)*: NELLIE S. BOOG/WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4135 ELLIOTT ISLAND ROAD, VIENNA, MARYLAND 21869

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ST. PAUL'S CEMETERY
Date: 11/20/01
20c. Location - City or Town, State: VIENNA, MARYLAND

21. Signature of Funeral Service Licensee: Leonard D. Zeller
22. Name and Address of Facility: ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET MD 21631

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Cardiomyopathy — Approximate Interval: years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Pulmonary Hypertension; Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D36783
29d. Date signed *(Month, Day, Year)*: 11/19/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Jeffery Etherton, MD 106 Milford St. Salisbury, MD 21801

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 21 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38805

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GLENYS L. BOYKIN

2. Date of Death (Month, Day, Year): NOV. 3 2001

3. Time of Death: 2:05 aM

4a. Facility Name (If not institution, give street and number): CHESAPEAKE HOSPICE HOUSE

4b. City, Town, or Location of Death: LINTHICUM

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 274-36-7678

8. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 57 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV. 29 1943

9. Birthplace (State or Foreign Country): OHIO

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 331 WENDE WAY

10f. Zip Code: 21061

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1962-84

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TECHNICIAN

18b. Kind of Business/Industry: NSA

17. Father's Name (First, Middle, Last): CURTIS ARMSTRONG

18. Mother's Name (First, Middle, Maiden Surname): TOMMIE M. BOYKIN

19a. Informant's Name/Relationship (Type, Print): ERIC BOYKIN (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13824 LORD FAIRFAX PLACE UPPER MARLBORO, MD. 20772

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MARYLAND VETERAN CEMETERY

Date: 11/9/01

20c. Location - City or Town, State: CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee: ▶ Larry G. Reese #000483

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Kidney Disease/uremia — 6 mo.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Diabetes Mellitus, Type 2 — years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) HOSPICE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ CHRISTINA M. YUAN LTC, MC

29c. License number: PA MD-040624-E

29d. Date signed (Month, Day, Year): 11/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 20910-5020 ASST. CHIEF, NEPH. SVC. WRAMC

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001

32. Registrar's Signature: ▶ Brenda B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

01-6544-031
B.K.S
WILLIAM C. BRIDGES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 38806

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
William Christopher Bridges	NOV. 17, 2001	0430 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
16000 BLOCK OF EMORY LANE	SILVER SPRING	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-15-8062	1☒M 2☐F	15 Yrs.			July 12, 1986	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Rockville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
16528 George Washington Drive	20853	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9	-	Student	High School

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Donald Bridges	Sassene Nolte

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James Donald Bridges/ Father	16528 George Washington Drive, Rockville, MD 20853

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Norbeck Memorial Park	November 21, 2001	Olney, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
M00689	Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Injuries

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivary Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No 3☐Probably 4☐Unknown	1☑Yes 2☐No	1☑Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) AT SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	11/17/01	4:09 AM	1☐Yes 2☑No	Driver of Motor Vehicle Impacts Fixed objects

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Street	16000 Block Emory Ln Silver Spring, Md

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. Pestaner, M.D	O.C.M.E	NOV. 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 21 2001	Geneva G. Saunders

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38807

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carl Taylor Bond
2. Date of Death (Month, Day, Year): November 15, 2001
3. Time of Death: 11:25 AM
4a. Facility Name (If not institution, give street and number): Villa Rosa Nursing Home
4b. City, Town, or Location of Death: Mitchellville
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 003-03-4829
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 27, 1920
9. Birthplace (State or Foreign Country): Rhode Island

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Greenbelt
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 122 Greenhill Rd.
10f. Zip Code: 20770
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Giva Yaar or Dates: 1940-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, Whita, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Economic Developer
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Carl T. Bond
18. Mother's Name (First, Middle, Maiden Surname): Mildred Wright

19a. tnformant's Name/Relationship (Type, Print): Ruth P. Bond / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 122 Greenhill Rd., Greenbelt, MD 20770

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or othar place): Uniform Services Univ.
Date: Nov. 16 2001
20c. Location - City or Town, State: Bethesda, MD

21. Signature of Funeral Service Licensee: Stephen D Lohrmann
22. Name and Address of Facility: Rapp Funeral and Cremation Services
Stephen D. Lohrmann P.A.
933 Gist Ave., Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Cerebrovascular Accident — 3 days

Due to (or as a consequence of): b. Atherosclorotic Vascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying ceuse given in Part I.: Senile Dementia

23b. Did tobacco uaa contribute to the cause of death? 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D22780
29d. Date signed (Month, Day, Year): November 16, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Peter M. Schissler, M.D. 7500 Greenway Center Drive, Ste. 430 Greenbelt, MD 20770

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-6579-033
B.K.S
JOHN C. BENNETT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar UNPENDED 121801: ITEMS #23a, 27 per ME G802 ss

Reg. No. 2001 38808

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JOHN C. BENNETT	NOV. 18, 2001	2335 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SOUTHERN MARYLAND HOSPITAL CENTER	CLINTON	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
437-29-8964	1 [X] M 2 [ ] F	31 Yrs.			JUNE 1, 1970	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	PRINCE GEORGES	WALDORF	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5008 NICHOLAS RD.	20602	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:	1 [ ] Yes 2 [X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
10		FORK LIFT DRIVER	COPAR CO.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
RONALD BENNETT	JOYCE O'STEEN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JOYCE O'STEEN/MOTHER	3033 H. OCTOBER PL., WALDORF, MD. 20602

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	TRINITY MEM. GARDENS	11/23/01	WALDORF, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
W.W. Chambers M00091	5801 CLEVELAND AVE. CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of deeth 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown	1 [X] Yes 2 [ ] No	1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [X] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. LaRon Locke, MD	O.C.M.E	NOV. 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. LaRon Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 21 2001	Denise G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38809

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jimmy K. Behram
2. Date of Death (Month, Day, Year): November 19, 2001
3. Time of Death: 1:27 PM
4a. Facility Name (If not institution, give street and number): 11215 Oak Leaf Drive Apt #2005
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-72-6612
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 7, 1924
9. Birthplace (State or Foreign Country): India

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 11215 Oak Leaf Drive Apt #2005
10f. Zip Code: 20901
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Indian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Air Traffic Controller
16b. Kind of Business/Industry: Aviation

17. Father's Name (First, Middle, Last): Khurshed Behram
18. Mother's Name (First, Middle, Maiden Surname): Docy Unknown

19a. Informant's Name/Relationship (Type, Print): Homai Behram / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11251 Oak Leaf Drive Apt #2005, Silver Spring, MD 20901

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: Nov 20, 2001
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: Robert A Sykes
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. cardiac arrest

Due to (or as a consequence of):
b. coronary artery disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. myocardial infarction — weeks

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lawrence Kelley MD
29c. License number: 47655
29d. Date signed (Month, Day, Year): 11/20/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lawrence Kelley, MD 7901 Maple Avenue, Takoma Park, MD

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38810

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NORMA G. BAUM

2. Date of Death Month / Day / Year: NOVEMBER 16, 2001

3. Time of Death: 9:25 AM

4a. Facility Name *(If not institution, give street and number)*: SUBURBAN HOSPITAL

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 151-12-6563

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: DEC. 24, 1924

9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residance of Decedant

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5707 English Court

10f. Zip Code: 20817-6258

10g. Citizen of Whet Country?: United States

11. Merital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bteck, White, atc.: *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elemantary/Secondery (0-12) / College (1-4or 5+): 5+

16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Businass/Industry: Own Home

17. Father's Neme *(First, Middle, Last)*: Harry Goldsmith

18. Mother's Neme *(First, Middle, Meiden Surname)*: Esther Chuckrow

19a. Informant's Name/Relationship *(Type, Print)*: Emanuel L. Baum / Husband

19b. Maiting Address *(Street and Number or Rural Routa Number, City or Town, Stete, Zip Code)*: 5707 English Court, Bethesda, MD 20817

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removet from State 4☐ Donetion 5☐ Othar *(Specify)*

20b. Place of Disposition *(Neme of cemetary, cremetory or other piece)*: Judean Memorial Gardens

Date: 11/18/01

20c. Location - City or Town, Steta: Olney, MD

21. Signature of Funeral Service Licensee

22. Name end Address of Facility: Danzansky Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrast, shock, or heart feilure. List only one cause on eech line.

Approximete Intervel Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in deeth)

a. Respiratory Arrest

Due to (or as a consequanca of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disaase or Injury thet initieted events resulting in death) Last

b. Cerebral Vascular Accident

Due to (or es a consequance of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uss contributs to the cause of death?: 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?: 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death?: 1☐ Yes 2☐ No

25. Was case referred to medical examiner?: 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Mennar of Death: 1☑ Naturet 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Data of Injury *(Month, Dey Year)*

28b. Time of Injury

M

28c. Injury at Work?: 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and plsca, and due to the cause(s) and manner steted.

29b. Signetura and titla of certifier

29c. License number: D0055099

29d. Date signed *(Month, Dey, Year)*: 11,16,2002

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Dr. Thaddeus W. Golden , 8600 Old Georgetown Rd. Bethesda, MD

State Registrar

31. Dete filed *(Month, Dey, Year)*: NOV 21 2001

32. Registrer's Signeture

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Norma Baum Illness @ 9:25 AM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #5, 11/29/2001, BMW, Montg. Co.

Certificate of Death

Reg. No. 2001 38811

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maude G. Bankett

2. Date of Death: Month NOVEMBER Day 16 Year 2001

3. Time of Death: 1:20PM

4a. Facility Name (If not institution, give street and number): Heartland Rehabilitation Center

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 240-09-9252 (~~9295~~)

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Apr. 13, 1915

9. Birthplace (State or Foreign Country): South Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: D.C.

10b. County: N/A

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2901 26th Street, N.E.

10f. Zip Code: 20018

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Animal Caretaker

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Edward Gause

18. Mother's Name (First, Middle, Maiden Surname): Rosa McDaniel

19a. Informant's Name/Relationship (Type, Print): Vaughn Tabron/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2928 17th Street, N.E., Washington, D.C. 20018

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Ft. Lincoln Cemetery

Date: 11/21/01

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Andre Thompson

22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W., Washington, D.C. 20012

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CONGESTIVE HEART FAILURE — 2years.

Due to (or as a consequence of):

b. RENAL FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. HYPERTENSION

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marilyn Corazzi MD

29c. License number: D40313

29d. Date signed (Month, Day, Year): November 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marilyn Corazzi, MD 6500 Riggs Road, Hyattsville, MD

State Registrar

31. Date filed (Month, Day, Year): NOV 23 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38812

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AUDREY C. BALL

2. Date of Death (Month, Day, Year): NOV. 14 2001

3. Time of Death: 1702 M

4a. Facility Name (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 217-18-0967

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 5 1913

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: ANNAPOLIS

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 722 GLENWOOD STREET

10f. Zip Code: 21401

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11th

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEKEEPING

16b. Kind of Business/Industry: PRIVATE FAMILY

17. Father's Name (First, Middle, Last): WILLIAM JACOBS

18. Mother's Name (First, Middle, Maiden Surname): AGNES HEBRON

19a. Informant's Name/Relationship (Type, Print): ANNA COLBERT (NEICE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 722 GLENWOOD ST. ANNAPOLIS, MARYLAND 21401

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MARYLAND VETERAN CEMETERY

Date: 11/19/01

20c. Location - City or Town, State: CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee: Larry D. Reese M00483

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Urosepsis — 24 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnent at time of deeth 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dehydration

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to tha cause(s) end manner stated.

29b. Signature and title of certifier: Sjoerd Beck, MD

29c. License number: D46052

29d. Date signed (Month, Day, Year): 11/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SJOERD BECK, MD 64 Franklin Street, Annapolis, MD.

State Registrar

31. Date filed (Month, Day, Year): NOV 19 2001

32. Registrar's Signature: Denise D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 38813

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Vivian Craig Charsha

2. Date of Death (Month, Day, Year): November 19, 2001

3. Time of Death: 0010

4e. Facility Name *(If not institution, give street and number)*: Harford Memorial Hospital

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 220-22-0285

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 10, 1926

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Perryville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1625 Ingleside Avenue

10f. Zip Code: 21903

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Twelve Years; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Personal Residence

17. Father's Name *(First, Middle, Last)*: Stanley Clarence Craig

18. Mother's Name *(First, Middle, Maiden Surname)*: Beulah Mae Taylor

19e. Informant's Name/Relationship *(Type, Print)*: Curtis Roger Charsha (husband)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1625 Ingleside Avenue, Perryville, Maryland 21903

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hopewell Cemetery

Date: 11/24/01

20c. Location - City or Town, State: Port Deposit, Maryland

21. Signature of Funeral Service Licensee: Thomas M. Patterson, Sr.

22. Name and Address of Facility: Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

0010 bam 11-19-01

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. [illegible]

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Charsha, Vivian Craig 11-19-01

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] MD

29c. License number: 042806

29d. Date signed *(Month, Day, Year)*: 11/21/01

10

30. Name and address of person who completed cause of death (Item 23a) *(Type, Print)*: [illegible]

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 21 2001

32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38814

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WADIE T. CRAIN JR.
2. Date of Death Month Day Year: NOV. 20, 2001
3. Time of Death: 1633
4a. Facility Name (If not institution, give street and number): UNION HOSPITAL
4b. City, Town, or Location of Death: ELKTON
4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 212-48-8964
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 52 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 15, 1949
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: CECIL
10c. City, Town or Locality: ELKTON
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 342 West MAIN ST.
10f. Zip Code: 21921
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Wh. te

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DISABLED
16b. Kind of Business/Industry: DISABLED

17. Father's Name (First, Middle, Last): WADIE CRAIN SR.
18. Mother's Name (First, Middle, Maiden Surname): PEARL Goodyear CRAIN

19a. Informant's Name/Relationship (Type, Print): FRANK CRAIN - SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2201 OLDEN AVE. NEWARK DEL. 19702

20a. Method of Disposition: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): R A Ferris INC.
Date: 11/21/01
20c. Location - City or Town, State: W. Chester PA. ELKTON, MD.

21. Signature of Funeral Service Licensee: Edward McKown
22. Name and Address of Facility: GEE Funeral Home 259 E. MAIN St

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Coronary Artery disease — >10yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Type II Diabetes

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: José Ma MD.
29c. License number: D44716
29d. Date signed (Month, Day, Year): November 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): José Ma 111 W. High St., Elkton MD. 21921

State Registrar

31. Date filed (Month, Day, Year): NOV 26 2001
32. Registrar's Signature: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38815

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Francis Vincent Cowens	November 21, 2001	9:15 PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Anne Arundel General Hospital	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
309-46-9051	X 1 M 2 F	61 Yrs.			Aug. 2, 1940	Washington DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Lothian	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
151 B. Street	20711	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 X Yes 2 No If Yes, Give Year or Dates: 1959-61	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		Plumber	Heating & Plumbing Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John J. Cowens	Estelle D. Thomas

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sallie A. Cowens - Wife	151 B. Street, Lothian, MD 20711

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Huntt Crematory	11-23-2001	Waldorf, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John P. Knisley MO1164	Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	a. CANCER OF LUNG	5 yr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 X Yes 2 No 3 Probably 4 Unknown	1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined			1 Yes 2 No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) X 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D08118	November 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
STANLEY WATKINS 900 BESTGATE RD ANNAPOLIS MD 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 29 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38816

Collick, Yvonne 212-40-9614

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Neme (First, Middle, Last): Yvonne Marcele Collick			2. Date of Death: Month Nov, Day 16, Year 2001	3. Time of Death: 0405
4a Facility Neme (If not institution, give street and number): Atlantic General Hospital		4b. City, Town, or Location of Death: Berlin	4c. County of Death: Worcester	
5. Social Security Number: 212-40-9614	6. Sex: 1☐M 2☒F	7. Age (In yrs. last birthday): 60 Yrs.	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year): June 26, 1941 / 9. Birthplace (State or Foreign Country): MD

Usuel Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Worcester	Berlin	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10411 Griffin Rd.	21811	U.S.

11. Meritel Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐Never Merried 2☐Merried 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yeer or Detes:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12th		n/a	n/a

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
Rudolph Hudson	Victoria Purnell

19e. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Glenda Holden/daughter	117 Elizabeth St., Berlin, MD 21811

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☒Buriel 2☐Cremation 3☐Removel from Stete 4☐Donation 5☐Other (Specify)	St. Paul's Cemetery	11/23/01	Berlin, MD

21. Signeture of Funerel Service Licensee	22. Neme end Address of Feciliity
	Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or compiications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

		Approximete intervel Between Onset end Death
Immediete Ceuse (Finel diseese or condition resulting in deeth)	e. myocardial infarction	1 hour
	Due to (or es a consequence of):	
Sequentielly list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest	b.	
	Due to (or es a consequence of):	
	c.	
	Due to (or es a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

hypertensive heart disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Deeth (Check only one)	
1☐Yes 2☒No	Hospitel: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Menner of Deeth	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☐Netured 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and menner as stated. 2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
physician	H44283	11/16/01

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Robert Durkin 9733 Healthway Drive Baltimore MD

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
NOV 19 2001	G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38817

Catherine Clarke

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
CATHERINE	M.	CLARKE	November 12 2001	1510 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-24-3691	1☐ M 2☒ F	86 Yrs.			November 9, 1915	Washington, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Bethesda	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5009 Sentinel Drive Unit 53	20816	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	–	Homemaker	Domestic

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Martin	Alice F. McTernan

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patricia C. Giebel/Daughter	6312 Hollins Dr., Bethesda, MD 20817

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Gate of Heaven Cemetery	11/15/01	Silver Spring, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kelly R Kenney CFSP	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Renal failures / Renal Insufficiency — 72hrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Left Ventricular systolic dysfunction

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month / Day / Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐ Yes 2☐ No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es steted. 2☐ **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yaer)
▶ [signature]	H0015097	11/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert A Cukr DO 100 E. Carroll St Salisbury MD 21801

State Registrar

31. Date filed (Month, Day, Yaer)	32. Registrar's Signature
NOV 16 2001	▶ Denise G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

12 DQ

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38818

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Theresa	Irene	Chamberlain	November 11, 2001	07:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2150 St. Lukes Road	Salisbury	Worcester

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
162-24-0409	1☐M 2☒F	72 Yrs.					July 26, 1929	Milton, PA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Worcester	Salisbury	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2150 St. Lukes Road	21804	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Registered Nurse	Nursing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Paul R. Baker	Fleda Auchenbaugh

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
John F. Chamberlain/Husband	2150 St. Lukes Rd., Salisbury, MD

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Wicomico Memorial Park	11/14/01	Salisbury, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ David A. Thompson M01051	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebral Vascular accident	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Hyperlipidemia

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Catherine Holmes	045005	11-12-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Catherine Holmes 1104 Healthway Dr Salisbury MD 21804

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 14 2001	▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

6 DQ

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38819

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas B. Contee
2. Date of Death (Month, Day, Year): November 22, 2001
3. Time of Death: 12:08 AM

4a. Facility Name (If not institution, give street and number): Bradford Oaks NSG & Rehab CTR
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-26-2084
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February 27, 1908
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Brandywine
10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 15203 Baden Naylor Road
10f. Zip Code: 20613
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farming
16b. Kind of Business/Industry: Agriculture

17. Father's Name (First, Middle, Last): William J. Contee
18. Mother's Name (First, Middle, Maiden Surname): Rebecca Green

19a. Informant's Name/Relationship (Type, Print): Dorothy Magruder/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5501 Accokeek Road Brandywine, Maryland 20613

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Nottingham Myers Chr. Cem.
Date: 11/29/01
20c. Location - City or Town, State: Upper Marlboro, Maryland

21. Signature of Funeral Service Licensee: [signature] 191
22. Name and Address of Facility: Adams Funeral Home P.A. Aquasco, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Coronary Artery Disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Hypertension
Due to (or as a consequence of):
c. Diabetes
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Emphysema
Renal Insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D0052741
29d. Date signed (Month, Day, Year): 11/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Caroline Caine 11701 Livingston Rd Ft Washington MD

State Registrar

31. Date filed (Month, Day, Year): NOV 27 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #23a-II, 11/26/2001, BMW, Montg.Co. AMEND ITEM #18 PER INF G841, 3/11/05 mH

Certificate of Death

Reg. No. 2001 38820

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES LEE CROSS

2. Date of Death (Month, Day, Year): November 12, 2001

3. Time of Death: 07:16AM

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 514-03-1232

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 24, 1918

9. Birthplace (State or Foreign Country): Missouri

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2910 Lindell Court

10f. Zip Code: 20902

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Physicist

16b. Kind of Business/Industry: Scientific

17. Father's Name (First, Middle, Last): Albert Lee Cross

18. Mother's Name (First, Middle, Maiden Surname): FAY SENEKER ~~Priscella Jane Morgan~~

19a. Informant's Name/Relationship (Type, Print): Jarrett L. Cross/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13501 Prices Distillery Road, Clarksburg, MD 20871

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory

Date: Nov 14, 2001

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Lewis A. Shoaff

22. Name and Address of Facility: Rapp Funeral & Cremation Services, 933 Gist Ave., Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	12 Hours
Due to (or as a consequence of):	b. STAPH AUREUS SEPTICEMIA	24 Hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Compression Fracature, 5th cervical veterbral body ~~Deterioum~~ ~~Fracture, 5th Cervical Vertebral Body~~

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D-57556

29d. Date signed (Month, Day, Year): November 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK MISHKIN, MD. 1830 E. MONUMENT, SUITE 9020, BALTIMORE MD 21287

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38821

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alice G. Crowder
2. Date of Death Month Day Year: November 15, 2001
3. Time of Death: 5:05 AM
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-30-1514
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 96 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb 27, 1905
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: DC
10b. County:
10c. City, Town or Location: Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 708 Quincy Street, NW
10f. Zip Code: 20011
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Telephone Operator
16b. Kind of Business/Industry: Telecommunications

17. Father's Name *(First, Middle, Last)*: James F. Lomax
18. Mother's Name *(First, Middle, Maiden Surname)*: Pearl M. Norris

19a. Informant's Name/Relationship *(Type, Print)*: Judie A. Deane / Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10501 Woodleigh Court, Beltsville, MD 20705

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery — Date: Nov 19, 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Lee R. Thomas
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Status Epilepticus — 6 weeks
Due to (or as a consequence of):
b. Cerebral Vascular Accident — 2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Frederick G. Barr MD
29c. License number: D22775
29d. Date signed *(Month, Day, Year)*: November 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frederick G. Barr, MD 5454 Wisconsin Avenue Suite 1345, Chevy Chase, MD 20815

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 19 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 38822

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JESSIE T. CARROLL
2. Date of Death (Month, Day, Year): Nov 17, 2001
3. Time of Death: 2:10 Am
4a. Facility Name (If not institution, give street and number): Gilcrest Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-30-5235
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 20, 1933
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1201 Valley Brook Court
10f. Zip Code: 21229
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foreman
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Louis Carroll
18. Mother's Name (First, Middle, Maiden Surname): Dora Holland

19a. Informant's Name/Relationship (Type, Print): Juanita Carroll (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1201 Valley Brook Ct, #H, Catonsville, Md 21229

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudoun Park Cem.
Date: 11/21/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Tonya K. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung cancer — 4 months
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: W. Anthony Riley, MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): November 17, 2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001
32. Registrar's Signature: Linda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

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To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

11/17/01 2:10 AM MEM

Jessie Carroll

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg No. 2001 38823

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Evelyn Edna Carlson	November 20, 2001	6:50 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Montgomery General Hospital	Olney	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
309-03-6076	1☐M 2☒F	89 Yrs.					Aug. 9, 1912	Marshall, IN

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	Lanham	1☐Yes 2☒No X

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7000 St. Anne's Street	20706	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Sales Representative	Children's Books

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Henry Barts	Gertrude Anders

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ronald C. Carlson - Son	7000 St. Anne's Street., Lanham, MD 20706

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Patton Cemetery	11/24/01	LaPorte, IN

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Dennis Pittman	Cutler Funeral Home LaPorte, IN 46351

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errast, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Pulmonary embolism	
Due to (or as a consequence of):	b. Deep Venous Thrombosis	2d
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Anoxic brain injury	3 wks
Due to (or as a consequence of):	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Deta of delivery Month Dey Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

s/p cardiac arrest

Dementia

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No 3☐Probably 4☐Unknown	1☐Yes 2☑No	1☐Yes 2☑No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ M Cowan	D50289	11/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK COWAN MD MONTGOMERY GENERAL HOSPITAL

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 23 2001	▶ Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38824

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Charles Franklin Cook	November 15, 2001	4:50 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1048 Forest Hills Avenue	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214 14 5936	1 [X] M 2 [ ] F	81 Yrs.			March 04, 1920	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Annapolis	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1048 Forest Hills Ave.	21401	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-45	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Inspector	City Water Department

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Wesley Cook	Lillie Mae Emmart

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Philip J. Cook (Son)	1658 Cliff Drive Edgewater, MD. 21037

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Hillcrest Cemetery	11-19-01	Annapolis, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Coronary artery disease	6 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

28. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D30718	11-16-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

[illegible] Cook, 2003 Carl Key, Hwy, Annapolis MD 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38825

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Arnold Clement Dupuis	November 15, 2001	5:52 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Harford Memorial Hospital	Havre de Grace	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
006-36-5851	1[X] M 2[ ] F	60 Yrs.			Dec. 19, 1940	Maine

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Cecil	Perryville	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
345 Broad St., Apt. 5	21903	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[ ] Married 3[ ] Widowed 4[X] Divorced	1[X] Yes 2[ ] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Salesman	Vacuum Cleaners

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Clement Dupuis	Mary Louise Chenelle

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Shirley Ritchie/Sister	65 Woodlyn Road, Rising Sun, MD 21911

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[ ] Burial 2[X] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	R. A. Ferris & Co., Inc.	11-19-01	West Chester, PA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Richard L. Goodie	R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung CA w metastases	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnency 4[ ] Pregnant at time of death 5[ ] Other (specify) _____ 9[ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[X] No	1[ ] Yes 2[X] No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1[ ] Yes 2[X] No	Hospital: 1[X] Inpatient 2[ ] ER/Outpatient 3[ ] DOA Other: 4[ ] Nursing Home 5[ ] Residence 8[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[illegible] MD	D42800	11/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

[illegible] MD 319 S. Union Ave Hav de Grace MD 21078

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 21 2001	[signature] D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

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Dupuis, Thomas Clement Sr 11/15/01 1752

7+1VA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar: Amend Item 26, 11|21|2001 Cecil Co., bam

Certificate of Death

Reg. No. 2001 38826

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Virgina Davis
2. Data of Death Month Day Year: November 20, 2001
3. Time of Death: 7:00 AM M
4a. Facility Nama (If not institution, give street and number): 3333 Old Elk Neck Road
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 229-58-2482
6. Sex: 1☐M 2☒F
7. Aga (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): September 19, 1917
9. Birthplace (State or Foraign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Insida City Limits: 1☐Yes ☒No
10e. Street and Number: 3333 Old Elk Neck Road
10f. Zip Code: 21921
10g. Citizan of What Country?: United States

11. Marital Status: 1☐Nevar Married ☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐Yas 2☒No If Yas, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐Yas 2☒No Specify:
14. Race - Amaricen Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
18b. Kind of Businass/Industry: Own Home

17. Fathar's Name (First, Middle, Last): Lafayette Smith
18. Mothar's Nama (First, Middle, Maidan Surname): Margaret England

19a. Informant's Name/Ralationship (Type, Print): Patricia Hylton/ Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda): 649 Nottingham Road, Elkton, Maryland 21921

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from Stata 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Nama of cematary, crematory or other place): North East Methodist
Date: November 24, 2001
20c. Location - City or Town, State: North East, Maryland

21. Signature of Funeral Service Licensee:
22. Nama and Address of Facility: Crouch Funeral Home 127 South Main Street, North East, Maryland 21901

Physician /Medical Examiner

23a. Part1. Enter tha diseasa, or complications that ceused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona ceusa on each lina. Approximate Intarval Batwean Onsat and Daath

Immediata Cause (Final disease or condition resulting in death): a. Respiratory Faelure
Dua to (or as a consequence of):
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseasa or injury that initiated events rasulting in daath) Last:
b. Cardiac Arrhythmia
Dua to (or as a consequance of):
c.
Dua to (or as a consequance of):
d.

IF FEMALE:
23b. Was decedent pregnant in tha past 12 months? 1☐Yas 2☐No 9☐Unknown
23c. If yes, outcoma of pregnancy 1☐Liva birth 2☐Fatal daath 3☐Ectopic pregnancy 4☐Pregnant at tima of death 5☐Othar (specify) 9☐Unknown
23d. Date of dalivery Month Day Year

Part II. **Other significant conditions** contributing to daath but not resulting in the underlying cause givan in Part I.
Alzheimers Dementia

23a. Did tobacco usa contributa to tha causa of daath? 1☐Yas 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No
24b. Wara autopsy findings availabla prior to complation of cause of daath? 1☐Yes 2☒No

25. Was casa refarred to medical examiner? 1☐Yas 2☒No

28. Placa of Daath (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Othar: 4☐Nursing Homa 5☒Residance ~~6☒Other (Specify) HOSPICE CARE~~

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Pending investigation 6☐Could not be datarmined
28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1☐Yas 2☐No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Route Numbar, City or Town, State)

29a. Cartifier (Check only one): 1☒**Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. 2☐**Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha ceuse(s) and mannar stated.

29b. Signatura and title of certifier: MD
29c. Licansa number: 056820
29d. Date signed (Month, Day, Year): 11/21/2001

30. Nama and address of person who completed cause of daath (Item 23a) (Type, Print): JOSLEEN NISNISAN MD 223 WEST MAIN ST. ELKTON MD 21921

State Registrar

31. Data filed (Month, Day, Year): NOV 21 2001
32. Registrar's Signatura: B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: Tha law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38827

NAME KNOWN TO PHYSICIAN: DREWS, IRWIN J.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Irwin John Drews

2. Date of Death (Month, Day, Year): November 25, 2001

3. Time of Death: 04:50P M

4a. Facility Name (If not institution, give street and number): VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death: PERRY POINT

4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 222-05-9524

6. Sex: 1 XX M 2 ☐ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 13,1921

9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: Delaware

10b. County: New Castle

10c. City, Town or Location: Wilmington

10d. Inside City Limits: XX Yes 2 ☐ No

10e. Street and Number: 1201 North Harrison Street

10f. Zip Code: 19806

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 ☐ No If Yes, Give Year or Dates: 1942-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): Eight Years

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): District Manager

16b. Kind of Business/Industry: Philadelphia Inquire

17. Father's Name (First, Middle, Last): Herman J. Drews

18. Mother's Name (First, Middle, Meiden Surname): Catherine Hoog

19a. Informant's Name/Relationship (Type, Print): Kathleen V. Frederick (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1337 Clifford Road, Wilmington, Delaware 19805

20a. Method of Disposition: XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Delaware Veterans Cemetery

Date: Nov. 29,2001

20c. Location - City or Town, State: Bear, Delaware

21. Signature of Funeral Service Licensee: ▶ Thomas M. Patterson, Sr.

22. Name and Address of Facility: Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death)

a. Aspiration pneumonia — Unknown

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant et time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Hypertension, Diabetus Mellitus, Hypothyroidism

Dementia

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was en autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steted. 2 ☐ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Samir Kheiri MD

29c. License number: D0052064

29d. Date signed (Month, Day, Year): November 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAMIR KHEIRI, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902

State Registrar

31. Dete filed (Month, Day, Year): NOV 26 2001

32. Registrar's Signature: ▶ B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Joseph M. Dyson
CJ
01-6554-017

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar UNPENDED 120601:ITEMS#23a,ptII,27,28a-f per MI G802 ss

Reg. No. 2001 38828

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Marvin Dyson

2. Date of Death: Month November Day 17 Year 2001

3. Time of Death: 01:35 PM

4a. Facility Name (If not institution, give street and number): 3445 A Weeping Willow Drive

4b. City, Town, or Location of Death: Waldorf

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 215-64-5906

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 46 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): September 11, 1955

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Charles

10c. City, Town or Location: Nanjemoy

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4110 Port Tobacco Rd.

10f. Zip Code: 20662

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1975-1975

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Relocator

18b. Kind of Business/Industry: Moving Company

17. Father's Name (First, Middle, Last): George Dyson, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mary Ida Barber

19a. Informant's Name/Relationship (Type, Print): Bonita Tibbs Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5145 Chicamuxen Rd., Indian Head, Md. 20640

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Sacred Heart Cemetery Date: November 26, 2001

20c. Location - City or Town, State: LaPlata, Maryland

21. Signature of Funeral Service Licensee: M00668

22. Name and Address of Facility: Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, 20640

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death): a. DROWNING

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

ALCOHOL INTOXICATION, PELVIC FRACTURE

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [X] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Scene

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined

28a. Date of Injury (Month, Day Yeer) Found: 11-16-01

28b. Time of Injury Found: 1:30p M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Found in water

28f. Location (Street and Number or Rural Route Number, City or Town, State): 3445-A Weeping Willow Dr., Waldorf, MD

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Pestaner, M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Yaar): November 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): NOV 26 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38829

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Virginia Hurt Dorse	November 16, 2001	10:02 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Annapolitan Assisted Living	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
228-05-3155	1☐M 2☒F	86 Yrs.			April 13, 1915	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Annapolis	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1820 Ritchie Highway	21401	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Lab Technician	Phillip Morris Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert H. Hurt	Lucy McKinney

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rose M. Brice/daughter	1820 Ritchie Highway Annapolis, MD 21401

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Baltimore Crematory	11/17/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Todd E. Tillar	John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. End Stage Alzheimers disease	10 yea
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular accident

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home (Assisted Living) 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Paul S Rhodes	MD D22028	11 16 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul S Rhodes M.D. 1667 Crofton Centre Crofton Md 21114

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	Donna P Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38830

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NETTA MARIE FARRELL
2. Data of Death (Month, Day, Year): NOVEMBER 14, 2001
3. Time of Death: 6:42 PM
4a. Facility Name (If not institution, give street and number): 748 South Park Drive
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 214-18-4844
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): April 20, 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 748 South Park Drive
10f. Zip Code: 21804
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
16b. Kind of Business/Industry: Telephone

17. Father's Name (First, Middle, Last): Raymond Thomas Davis
18. Mother's Name (First, Middle, Maiden Surname): Della E. Bedsworth

19a. Informant's Name/Relationship (Type, Print): Patrick Farrell/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 113 79th St., Apt. B, Ocean City, MD 21842

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parsons Cemetery
Date: 11/19/01
20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: David A. Thompson MO1051
22. Name and Address of Facility: Holloway Funeral Home Professional Association, 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. METASTATIC PANCREATIC CANCER — 7 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R Clinton, MD
29c. License number: D0056776
29d. Date signed (Month, Day, Year): 11/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert L. Clinton, M.D 145 E. Carroll St., A-1 Salisbury, MD 21801

State Registrar

31. Date filed (Month, Day, Year): NOV 16 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

20 DQ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38831

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Elaine M Fisher	NOVEMBER 24, 2001	10:11 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ANNE ARUNDEL MEDICAL CENTER	ANNAPOLIS	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
229-03-4413	1 ☐ M 2 ☒ F	83 Yrs.			MAR. 27, 1918	COLORADO

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	EDGEWATER	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
118 RIVERSIDE ROAD	21037	UNITED STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	HOMEMAKER	HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CHARLES ELMER McCLINTOCK	CATHERINE BENNETT

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JUDY JAMES (DAUGHTER)	24302 PLANTATION DR. N.E. ATLANTA, GA. 30324

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Buriel 2 ☒ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)	METROPOLITAN CREMATORY	11-26-01	ALEXANDRIA, VA.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: GEORGE P. KALAS FUNERAL HOME, 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Gastrointestinal Hemorrhage	24 hours
Due to (or as a consequence of):	b. Esophagitis, reflux	4 years
Due to (or as a consequence of):	c. Duodenal Ulcer Disease	4 years
Due to (or as a consequence of):	d.	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Dey Year
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnent at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Depression

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Neturet 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Charles E King MD	D 41618	November 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles E. King, MD 621 Ridgely Ave #201, Annapolis MD 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 27 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 2001 38832

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances Helen Foster

2. Date of Death: Month November Day 15 Year 2001

3. Time of Death: 6:20 AM

4a. Facility Name (If not institution, give street and number): Heritage Harbour Health & Rehabilitation Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 220-07-4289

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 22, 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 700 Americana Drive #42

10f. Zip Code: 21403

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant

16b. Kind of Business/Industry: Accounting

17. Father's Name (First, Middle, Last): Frank J. Russell

18. Mother's Name (First, Middle, Maiden Surname): Helen Tillery

19a. Informant's Name/Relationship (Type, Print): Donald Foster/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 700 Americana Drive #42 Annapolis, MD 21403

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Crematory

Date: 11/17/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Todd E. Tiller

22. Name and Address of Facility: John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disaesa, or complicetions that causad the death. Do not entar the mode of dying, such as cardiec or respiretory arrest, shock, or haart feilure. List only ona cause on aach line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
e. Advanced Dementia — months

Due to (or as a consequence of):
b. Chronic Lymphocytic Leukemia — months

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or es a consequence of):
c. Diabetes mellitus — yrs

Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signetura and title of certifier: ▶ N. Ja MD

29c. Licansa number: D41978

29d. Date signed (Month, Day, Year): 11-16-200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nader Tavakoli 4000 Mitchellville Dr A312 Bowie MD 20716

State Registrar

31. Dete filed (Month, Day, Year): NOV 19 2001

32. Registrer's Signeture: ▶ Donna B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38833

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT L. GRAY
2. Date of Death (Month, Day, Year): NOVEMBER 18,2001
3. Time of Death: 12:55 PM
4a. Facility Name (If not institution, give street and number): 4719 BREADY ROAD
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 217-30-0892
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept.22,1936
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 4719 Bready Road
10f. Zip Code: 20853
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1955-1956
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator
16b. Kind of Business/Industry: Tile Company
17. Father's Name (First, Middle, Last): William T. Gray
18. Mother's Name (First, Middle, Maiden Surname): Lois Thompson
19a. Informant's Name/Relationship (Type, Print): Nadine J. Gray / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4719 Bready Road, Rockville, Md. 20853
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Norbeck Memorial Park | Date: 11/21/01
20c. Location - City or Town, State: Olney, Maryland
21. Signature of Funeral Service Licensee: ▶ Muriel H. Barber
22. Name and Address of Facility: Muriel H. Barber Funeral Home, P. O. Box 5038, Laytonsville, Md. 20882

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Metastatic Colon Cancer	18 Months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ P. Henjum, M.D.
29c. License number: D 35045
29d. Date signed (Month, Day, Year): NOVEMBER 19,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PHILIP G. HENJUM, M.D. 3416 OLANDWOOD CT., #204, OLNEY, MD. 20832

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001
32. Registrar's Signature: ▶ Penny G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38834

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Muriel C. Gill

2. Date of Death (Month, Day, Year): November 15, 2001

3. Time of Death: 8:40AM

4a. Facility Name (If not institution, give street and number): Arden Courts

4b. City, Town, or Location of Death: Potomac

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 155-18-6567

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 17, 1920

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Virginia

10b. County: Fairfax

10c. City, Town or Location: McLean

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1609 Maddux Lane

10f. Zip Code: 22101

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada complated): Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Wesley Craig

18. Mother's Name (First, Middle, Maiden Surname): Claire Fleetwood

19a. Informant's Name/Relationship (Type, Print): Ellen Miller/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1609 Maddux Lane, McLean, Virginia 22101

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harbourton Cemetery | Date: Nov. 20 2001

20c. Location - City or Town, State: Hopewell, New Jersey

21. Signature of Funeral Service Licensee: David E. Perry, M00803

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona causa on aach lina.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):
b. hypertension

Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to complation of cause of death? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lila T. McConnell

29c. License number: D35456

29d. Date signed (Month, Day, Year): 11/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lila T. McConnell, M.D. 5530 Wisconsin Avenue, #1400, Chevy Chase, MD 20815

State Registrar

31. Date filed (Month, Day, Year): NOV 19 2001

32. Registrar's Signature: Lenora B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38835

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Robert James Grant, Jr.	November 24, 2001	10:47 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Anne Arundel Medical Center	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
184-36-5006	1 X M 2 F	55 Yrs.			Sep. 14, 1946	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Lothian	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5497 Solomons Island Rd.	20711	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 XX Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Educator	A.A. County Schools

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert James Grant, Sr.	Ruth Anne Fawley

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dianne M. Grant/ Wife	5497 Solomons Island Rd. Lothian, MD 20711

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 XX Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Metropolitan Crematory		Alexandria, VA

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: George P. Kalas Funeral Home, 2973 Solomons Island Rd. Edgewater, MD 21037

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Kidney Cancer	Months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetel death 3 Ectopic pregnancy 4 Pregnent at time of death 5 Other (specify) 9 Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 X No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D0051301	November 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kevin Knopf, M.D. 900 Bestgate Road, Suite 300 Annapolis, MD 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 27 2001	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38836

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Laura M. Garrity

2. Date of Death: Month Nov. Day 17, Year 2001

3. Time of Death: 6:00 am

4a. Facility Name (If not institution, give street and number): Somerford Place

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 577-18-0564

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar. 31, 1913

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Arnold

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 873 Willys Drive

10f. Zip Code: 21012

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Aaron Green

18. Mother's Name (First, Middle, Maiden Surname): Mary Ellen Dixon

19a. Informant's Name/Relationship (Type, Print): Margaret Krashoc/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 873 Willys Drive, Arnold, MD 21012

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: Nov 21 2001

20c. Location - City or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: Thomas J. Ahern

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE, CHRONIC TB

Due to (or as a consequence of):

b. EMPHYSEMA - COPD, Severe YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

BREAST CA. PERIPHERAL VASC

DS. OSTEOPOROSIS with FRACTURES

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D23-142

29d. Date signed (Month, Day, Year): 11/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type/Print): S.D. KRIKOS, M.D. 104 RIDGELY AVE ANNAPOLIS MD 21401

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001

32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38837

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louis F. Grill, Sr.

2. Date of Death: Month Nov. Day 18, Year 2001

3. Time of Death: 3:09 a M

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215-09-5548

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

6. Date of Birth (Month, Day, Year): Nov 13, 1916

9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Arnold

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1029 Placid Court

10f. Zip Code: 21012

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Engineer

16b. Kind of Business/Industry: Kaiser Corp.

17. Father's Name (First, Middle, Last): John Grill

18. Mother's Name (First, Middle, Maiden Surname): Josephine Chada

19a. Informant's Name/Relationship (Type, Print): Louis Grill, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 396 Kings College Drive, Arnold, MD 21012

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lakemont Memorial

Date: Nov. 20, 2001

20c. Location - City or Town, State: Davidsonville, MD

21. Signature of Funeral Service Licensee: Thomas Allen

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock — 72d

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hairy Cell Leukemia — >1year

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D24804

29d. Date signed (Month, Day, Year): 11/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Peterson MD AAMC Annapolis Md 21401

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

NOV 21 2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38838

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stephen W. Haddaway
2. Date of Death: Month 09 Day 06 Year 01
3. Time of Death: 6:15 pm
4a. Facility Name (If not institution, give street and number): DORCHESTER GENERAL HOSPITAL
4b. City, Town, or Location of Death: CAMBRIDGE
4c. County of Death: DORCHESTER

Funeral Director

5. Social Security Number: 218-20-5329
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG 24, 1921
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: DORCHESTER
10c. City, Town or Location: CAMBRIDGE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 520 GLENBURN AVE.
10f. Zip Code: 21613
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired): MACHINE OPERATOR
16b. Kind of Business/Industry: FOOD CANNING

17. Father's Name (First, Middle, Last): WILLIAM HENRY HADDAWAY
18. Mothar's Name (First, Middle, Meiden Surname): EMILY ELLEN PHILLIPS

19a. Informant's Name/Ralationship (Type, Print): REBA E. JAMES/SISTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO BOX 151,21530 EAST COPPERTOWN RD TILGHMAN MD21671

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other (Specify)
20b. Placa of Disposition (Neme of cemetery, cremetory or other piece): MD VETERANS CEMETERY
Date: 9-11-01
20c. Location - City or Town, State: HURLOCK, MD

21. Signeture of Funerel Service Licensee: ▶ JOHN R. MERCER JR
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications thet caused the death. Do not antar the mode ot dying, such es cardiec or respiratory arrast, shock, or heert feilure. List only one cause on eech line.

Approximata Interval Between Onset end Death

Immediate Cause (Final diseese or condition resulting in death)
a. Congestive Heart Failure — 4 days
Due to (or as a consequenca of):
b. COPD — 10 years

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Last
Due to (or as a consequance of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Lung Cancer
Coronary Artery Disease

23b. Did tobacco use contribute to the causes of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time ot Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Pleca of Injury - At home, tarm, street, tactory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To tha best of my knowledge, daath occurred at the time, date and placa, and due to the causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis ot examination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and manner stated.

29b. Signature and litle of certifier: ▶ E Tanman md
29c. License number: D0014349
29d. Date signed (Month, Day, Year): 9-6-01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Eyup Tanman MD 15 Franklin St. Cambridge, MD 21613

State Registrar

31. Date filed (Month, Day, Year): SEP 10 2001
32. Registrar's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38839

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET POWELL HEARNE
2. Date of Death: Month November Day 19 Year 2001
3. Time of Death: 10:13 a.m.
4a. Facility Name (If not institution, give street and number): Wicomico Nursing Home
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 219-05-3967
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): December 5, 1912
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 900 Booth Street
10f. Zip Code: 21801
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+): –
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper
16b. Kind of Business/Industry: Shore Distributors

17. Father's Name (First, Middle, Last): Paul Crisfield Powell
18. Mother's Name (First, Middle, Maiden Surname): Martha Johnson

19a. Informant's Name/Relationship (Type, Print): Earl W. Hearne/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 600 Regency Dr., Salisbury, MD 21804

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parsons Cemetery
Date: 11/21/01
20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: David A. Compton M0105
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary edema
Due to (or as a consequence of):
b. CHF exacerbation
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION, RENAL FAILURE, CHRONIC ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D0057709
29d. Date signed (Month, Day, Year): 11/19/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sanjay Bangarulingam, M.D. 614 Eastern Shore Drive Salisbury MD 21804

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001
32. Registrar's Signature: Denise G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Margaret Hearn

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38840

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WALTER SCOTT HOOPER SR
2. Date of Death Month Day Year: November 14, 2001
3. Time of Death: 5:05 PM
4a. Facility Name (If not institution, give street and number): 311 Lillian Street
4b. City, Town, or Location of Death: Hebron
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 219-14-3359
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February 4, 1925
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Hebron
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 311 Lillian Street
10f. Zip Code: 21830
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Preston Trucking Co.

17. Father's Name (First, Middle, Last): William A. Hooper
18. Mother's Name (First, Middle, Maiden Surname): Ruby Ethel Truitt

19a. Informent's Name/Relationship (Type, Print): Barbara A. Hooper/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 311 Lillian St., Hebron, MD 21830

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mardela Memorial Cemetery
Date: 11/17/01
20c. Location - City or Town, State: Mardela Springs, MD

21. Signature of Funeral Service Licensee: Keith R Dewey CFSP
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Asystole — minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
b. Myocardial infarction — minutes
Due to (or as a consequence of):
c. Coronary Artery Disease — years
Due to (or as a consequence of):
d. Atherosclerosis — years

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D36783
29d. Date signed (Month, Day, Year): 11/19/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeffrey Fitherton, MD PRMC Salisbury MD. 21804

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001
32. Registrar's Signature: Geneva G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#23a perPHYG803 1/15/02 EW

Certificate of Death

Reg. No. 2001 38841

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Thomas R. Holden, Jr.	NOV.	18	2001	0003 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-42-2322	1☒M 2☐F	55 Yrs.			Oct 7, 1946	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Somerset	Princess Anne	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
30122 Deal Island Rd.	21853	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		n/a	n/a

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas R. Holden, Sr.	Hazel G. Stevenson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Hazel G. Milbourne/mother	2381 Worcester Highway, Pocomoke, MD 21851

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Green Acres Mem Park	11/23/01	Salisbury, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiomyopathy	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. ~~Severe HTN~~ C.A.D.	
	Due to (or as a consequence of): c. ~~CAD~~	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ DO	H54827	11/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Investcor Gutierrez DO 106 Main St Suite 201 Salisbury MD 21804

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Thomas Holden 213-42-2322 11/18/01 00:03

UHP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38842

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
HAVENS	GLEASON	HILDRETH JR	November 11, 2001	7:05 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
914 Montrose Drive	Salisbury	Wicomico

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
098-14-2148	1 [X] M 2 [ ] F	79 Yrs.			December 18, 1921	New York

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Salisbury	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
914 Montrose Drive	21804	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Coast Guard	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	—	Mail Carrier	U.S. Postal Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Havens Gleason Hildreth Sr.	Carrie May Fogg

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joyce Hildreth/Wife	914 Montrose Dr., Salisbury, MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Dennis Cemetery	11/15/01	Willards, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature] LFSP	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Transitional Cell Bladder Cancer	3 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D36576	11/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ronald P. Trawitz MD 560 Riverside Dr. Salisb. MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 16 2001	▶ [signature] G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Lot 1
DR VA

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38843

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
JOHN	LEE	HUTCHERSON JR.	NOVEMBER 13 2001	7:20 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
31262 CARIOCA RD	DELMAR	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
161-32-6516	1 [X] M 2 [ ] F	64 Yrs.			08-07-1937	PENNSYLVANIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	WICOMICO	DELMAR	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
31262 CARIOCA RD	21875	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	JOB ESTIMATOR	MILITARY DEFENSE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOHN LEE HUTCHERSON, SR	LOIS SIMMS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PATRICIA V. HUTCHERSON - WIFE	31262 CARIOCA RD. DELMAR, MD 21875

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	CREMATORY OF DELMARVA	11-15-01	DELMAR, DELAWARE

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	705 E. MAIN ST. 21804 BOUNDS FUNERAL HOME, INC. SALISBURY, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Malignant Astrocytoma	YRS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D29105	11/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Christian Huddleston 106 Milford St. Salisbury, MD 21804

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 15 2001	▶ [signature] G Sparks

2+1/A PQ

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38844

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Jeanette M. Horn	November 16, 2001	10:12a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Hillside Home Assisted Living	Clarksville	Howard

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-16-5897	1☐ M 2☒ F	84 Yrs.			Sept 18, 1917	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Kensington	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2911 Kensintgon Blvd.	20895	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Cornelius van Vliet	Daisy R. Bennett

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Henry H. Horn / Son	8208 Cool Creek Court, Laurel, MD 20723

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	George Washington Cemetery	Nov 19, 2001	Adelphi, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John L Chipole	Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Dementia	5 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Data of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Dysphagia

Anemia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Assisted Living

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MA	D52481	November 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David H. Plotkin, MD 18110 Prince Phillip Drive, #304, Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 38845

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Randy Hooks		Nov. 16, 2001	6:10pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital	Clinton	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-84-3131	1☒ M 2☐ F	37 Yrs.			Feb.3,1964	Wash.,D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
D.C.	none	Washington,D.C.	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
51 Elmira Street,S.W.	20032	USA

11. Merifel Stetus	12. Wes Decedent Ever In U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Detes:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
	4	Actor	Entertainment

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
Dan Hooks	Edith Hall

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edith Hooks/ Mother	51 Elmira Street, S.W. Washington,D.C.20032

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Data	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)	Lincoln Cemetery	11-23-01	Suitland, Md.

21. Signature of Funeral Service Licensee	22. Neme and Address of Fecility
Dane de Mata	Universal II Mortuary,Inc. 411 Kennedy St.,N.W. Wash.,D.C. 20011

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List *only one* cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Causa (Final disease or condition resulting in death)	a. Bilateral Pneumonia	7 days
Dua to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Acute Hepatitis	7 days
Due to (or as a consequence of):		
	c. H.I.V.	6 years
Due to (or as a consequence of):		
	d.	

Part ff. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was casa referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yas 2☑ No	Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the causa(s) and menner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or Investigation, In my opinion, death occurred at tha time, data and place, and dua to the cause(s) and menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD Attend	D-24535	11.19.01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)
Laxmi Berwa,M.D. 7700 Old Branch Avenue, Clinton, Maryland

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 21 2001	Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

HOOKS, RANDY on 11-16-01 @ 1810

Dr. BERWA MA# 465354

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38846

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Adelheid K. Hohenstein
2. Date of Death Month Day Year: November 19, 2001
3. Time of Death: 10:00 P M
4a. Facility Name (If not institution, give street and number): Casey House
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 214-58-3232
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 5, 1934
9. Birthplace (State or Foreign Country): Czechoslavakia

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7019 Adelphia Road
10f. Zip Code: 20782
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
18b. Kind of Business/Industry: German Embassy

17. Father's Name (First, Middle, Last): Karl Kupa
18. Mother's Name (First, Middle, Maiden Surname): Adelheid Angerbauer

19a. Informant's Name/Relationship (Type, Print): James R. Farmer/ Cousin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1 Shady View Court, Brookville, MD 20833

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): George Washington/ Mt. Lebanon Cemetery
Date: Nov. 24, 2001
20c. Location - City or Town, State: Adelphi, MD

21. Signature of Funeral Service Licensee: Stuart D. Lohmann
22. Name and Address of Facility: Rapp Funeral & Cremation Services 933 Gist Ave., Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Carcinoma — 3 months
Due to (or as a consequence of):
b. Colon Cancer — 6 months
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: E.P. Libre MD
29c. License number: D09470
29d. Date signed (Month, Day, Year): November 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): E.P. Libre, M.D. 10400 Connecticut Avenue Kensington, MD 20895

State Registrar

31. Date filed (Month, Day, Year): NOV 23 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMENDED ITEMS#17 per fh G802 121101 ss

Reg. No. 2001 38847

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Helen	Marie	Hendry	November	13,	2001	9:25 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Nursing & Rehab, Center	Burtonsville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-80-3055	1☐ M 2☒ F	85 Yrs.					Sept 06,1916	South Dakota

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Silver Spring	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
116 Granville Drive	20901	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	1	Housemaker	Own home

17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)	
Casper	T.	~~Schueth~~ ~~Hendry~~	Rosena	Luchsinger

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alan Hendry/Son	7772 Virginia Oaks Drive, Gainesville, VA 20155

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)	Uniformed Services Univer	Nov 16, 2001	Bethesda, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Stella A. Lohmann	Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Cerebrovascular Accident

Due to (or as a consequence of):

c. Dementia

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Marina Goldmark, MD	D25348	November 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aimee Seidman, M.D. 2309 Shorefield Road, Wheaton, MD 20902-1825

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 23 2001	Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38848

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Grace Marie Hunter			November 18 2001	9:30 PM
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
Mariner Health of North Arundel	Glen Burnie		Anne Arundel	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-05-0105	1☐M 2☒F	85 Yrs.			May 23, 1916	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
California	Riverside	LaQuinta	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
55-201 Tanglewood	92253	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Owner	Flower Shop

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Lester Benjamin Wayson	Gertrude King

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edward O. Wayson, Sr./nephew	55-021 Tanglewood LaQuinta, CA 92253

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Mt. Zion Cemetery	11/23/01	Lothian, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Todd E. Liller	John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Carcinoma of Breast	3 Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Type II Diabetes Mellitus

Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Wlymiac MD Attending Doctor	D21684	11-19-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C-V. CYRIAC-M.D 8021 RITCH ST UNIT, PASADENA, MD 21122

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 21 2001	▶ Donna B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38849

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
ENZA HANSEN	NOV. 17, 2001	2:14 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ANNE ARUNDEL MEDICAL CENTER	ANNAPOLIS	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
267 72 1297	1☐M 2☒F	95 Yrs.			AUG. 14, 1906	ITALY

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	ANNAPOLIS	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
570 BELLERIVE DRIVE	21401	UNITED STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	HOMEMAKER	HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
STANISLAU JORIO	MARIANINA DeHONESTI

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SONJA R. JACYKEWYCZ (DAUGHTER)	1886 LUCE CREEK DRIVE ANNAPOLIS, MD. 21401

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	METROPOLITAN CREMATORY	11-19-01	ALEXANDRIA, VA.

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. cerebrovascular accident	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. multiple brain infarcts	
	Due to (or as a consequence of): c. Atrial fibrilation	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D0051437	11/18/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OKEOWO DARCY IBITOYE AAMC 64 FRANKLIN ST ANNAPOLIS MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38850

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Geraldine Hyman

2. Date of Death Month Day Year: November 13, 2001

3. Time of Death: 1 41 pm M

4a. Facility Name (If not institution, give street and number): University of Maryland Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-30-7185

8. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB. 11 1933

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: ANNAPOLIS

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 24 LAFAYETTE AVENUE

10f. Zip Code: 21401

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11th

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CAFETERIA WORKER

18b. Kind of Business/Industry: ANNE ARUNDEL CO. BOARD OF EDUCATION

17. Father's Name (First, Middle, Last): CHARLES MOBRAY

18. Mother's Name (First, Middle, Maiden Surname): BEULAH WILLIAMS

19a. Informant's Name/Relationship (Type, Print): THEODORE HYMAN SR. (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 24 LAFAYETTE AVE. ANNAPOLIS, MD. 21401

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MARYLAND VETERAN CEMETERY

Date: 11/20/01

20c. Location - City or Town, State: CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee: Larry D. Reese M00483

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Leaking Anastomosis of thoracic Aneurysm Repair

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Diffuse Coagulopathy

Due to (or as a consequence of):

c. Thoracic and Arch Aortic aneurysm

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: SEPEHR NAFICY

29c. License number: 13951

29d. Date signed (Month, Day, Year): November 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SEPEHR NAFICY 22 South Greene St. Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): NOV 16 2001

32. Registrar's Signature: Denise B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38851

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Yvonne McCallister Ireland
2. Date of Death (Month, Day, Year): Nov. 18 2001
3. Time of Death: 2145
4a. Facility Name (If not institution, give street and number): Dorchester General Hospital
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 213-44-2306
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 10 1909
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 1256 Hudson Road
10f. Zip Code: 21613
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): James Garfield McCallister
18. Mother's Name (First, Middle, Maiden Surname): Lulu Price

19a. Informant's Name/Relationship (Type, Print): Kathleen Kirby - daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1544 Chatham Colony Court, Reston, VA 20190

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Salisbury Crematory
Date: 11/20
20c. Location - City or Town, State: Salisbury, Maryland

21. Signature of Funeral Service Licensee: ▶ Kenneth R Thomas Jr.
22. Name and Address of Facility: Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	MYOCARDIAL INFARCTION	15 minutes
Due to (or as a consequence of): b.	ATHEROSCLEROSIS	4 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: MULTI-INFARCTION DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Michael A. Moskowicz MD.
29c. License number: D-16609
29d. Date signed (Month, Day, Year): DECEMBER 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL A. MOSKOWICZ MD. 503 BYRD ST. CAMBRIDGE MARYLAND 21613

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001
32. Registrar's Signature: ▶ Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38852

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
MARY	MILLER	INGRAHAM	NOV.	16,	2001	12:10A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
CASEY HOUSE	ROCKVILLE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-48-0634	1☐ M 2☒ F	93 Yrs.					SEPT. 1, 1908	VIRGINIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	PRINCE GEORGES	ADELPHI	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10120 RIGGS RD.	20783	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+) 4	EDITOR	SMITHSONIAN INSTITUTE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ANDREW LUTHER MILLER	LYDIA VIRGINIA CUPP

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARY JANE MATHEWS/DAUGHTER	16717 GOOSENECK TERR., OLNEY, MD. 20832

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	CHAMBERS CREMATORY	11/16/01	RIVERDALE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ W. W. Chambers M00091	5801 CLEVELAND AVE. CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC RENAL FAILURE — MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residance 8☒ Other (Specify) HOSPICE

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ E. P. Libre MD	D09470	NOV. 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. P. LIBRE, M.D. 10400 CONNECTICUT AVE., KENSINGTON, MD. 20895

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	Renee G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38853

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PRESTON PHILIP JOHNSON

2. Date of Death (Month, Day, Year): NOVEMBER 9 2001

3. Time of Death: 2245 M

4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 222-14-4084

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV 8, 1924

9. Birthplace *(State or Foreign Country)*: DELAWARE

Usual Residance of Decedent

10a. State: DELAWARE

10b. County: SUSSEX

10c. City, Town or Location: MILLSBORO

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2 MOORE'S CROSSING

10f. Zip Code: 19966

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Ever in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1 [ ] Yas 2 [X] No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* WHITE

15. Decedant's Education *(Specify only highast grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedant's Usual Occupation *(Give kind of work dona during most of working life. DO NOT usa ratired)*: SUPERVISOR

18b. Kind of Businass/Industry: DELAWARE DEPARTMENT OF TRANSPORTATION

17. Fathar's Nama *(First, Middle, Last)*: PHILIP JOHNSON

18. Mothar's Nama *(First, Middle, Maiden Surname)*: MOLLIE LAWSON

19a. Informant's Name/Relationship *(Type, Print)*: FAYE E. KING JOHNSON / WIFE

19b. Mailing Address *(Street and Numbar or Rural Route Number, City or Town, State, Zip Code)*: 2 MOORE'S CROSSING, MILLSBORO, DELAWARE 19966

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, crematory or othar placa)*: MILLSBORO CEMETERY

Data: 11/13/2001

20c. Location - City or Town, Stata: MILLSBORO, DELAWARE

21. Signatura of Funaral Service Licensee: Richard T. Watson

22. Nama and Address of Facility: WATSON FUNERAL HOME, INC., MILLSBORO, DE 19966

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications thet caused the daeth. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediata Cause (Finat disease or condition resulting in daath):
a. Cardiogenic Shock — Hours

Sequentially list conditions, if any, laading to immediata causa. Entar Underlying Causa (Disaasa or injury that initiated events rasulting in daath) Last:
Due to (or as a consequence of):
b. Massive Antrior Wall Myocardial Infarction — 24 hours
Due to (or as a consequence of):
c. Coronary Artery Disease — Years
Due to (or as a consequence of):
d. Atherosclerosis — Years.

IF FEMALE:
23b. Was decedant pregnant in the past 12 months? 1 [ ] Yas 2 [ ] No 9 [ ] Unknown

23c. If yas, outcoma of pregnancy: 1 [ ] Live birth 2 [ ] Fatal daath 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Othar *(specify)* _____ 9 [ ] Unknown

23d. Data of dalivary: Month / Day / Year

Part II. **Other significant conditions** contributing to daath but not rasulting in the underlying cause givan in Part I.

Thoracic Aorta Aneurysm — Hx HTN

Hx Abd Aorta Aneurysm — Acute Renal failure

Periph. Vascular Disease

23a. Did tobacco use contribute to the cause of death? 1 [ ] Yas 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings available prior to completion of cause of daath? 1 [ ] Yes 2 [ ] No

25. Was cesa raferred to medical examiner? 1 [ ] Yas 2 [X] No

28. Placa of Daath *(Check only one)*: Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA Othar: 4 [ ] Nursing Homa 5 [ ] Residanca 8 [ ] Othar *(Specify)*

27. Manner of Daath: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Dascribe how injury occurred

28a. Placa of Injury - At home, farm, straat, factory, office building, etc. *(Specify)*

28f. Location *(Straat and Numbar or Rural Routa Number, City or Town, Stata)*

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Cartifier *(Check only one)*: 1 [X] **Certifying Physician:** To tha best of my knowledga, daath occurred at the tima, date and placa, and dua to tha causa(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of certifier: [signature]

29c. Licensa number: D44063

29d. Data signed *(Month, Day, Year)*: 11.10.2001

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): Joseph Cinderella MD 106 Milford St 605 Salisbury MD 21804

State Registrar

31. Data filed *(Month, Day, Year)*: NOV 15 2001

32. Registrar's Signatura: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

PRESTON JOHNSON 222-14-4034

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38854

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard N. Joyner
2. Date of Death (Month, Day, Year): November 20, 2001
3. Time of Death: 2:05AM
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-28-0767
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 1, 1923
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Clarksburg
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 12428 Dancrest Drive
10f. Zip Code: 20871
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: World War II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Customer Representative
16b. Kind of Business/Industry: Gas & Light Company

17. Father's Name (First, Middle, Last): Ryland L. Joyner
18. Mother's Name (First, Middle, Maiden Surname): Helena C. Reith

19a. Informant's Name/Relationship (Type, Print): Diana A. Bradley/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12428 Dancrest Drive, Clarksburg, Maryland 20871

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: Nov 23 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: David E. Perry · M00803
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION PNEUMONIA
Due to (or as a consequence of):
b. SEPSIS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. ACUTE RENAL FAILURE
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: H51280
29d. Date signed (Month, Day, Year): 11-20-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anushiravan Dadgar, D.O. 13219 Executive Park Terrace, Germantown, MD 20874

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38855

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
JUANITA JOHNSON	NOV. 16, 2001	12:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
237-22-3086	1☐M 2☒F	84 Yrs.			Sept.2,1917	N. Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Gaithersburg	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5120 Brookeville Road	20882	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	☒Yes 2☐No If Yes, Give Year or Dates: 45-46	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2 yrs	Food Service Manager	Montgomery Colleg

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Donnell A. Bell	Lousettia Sanders

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Wendell Johnson (Son)	10805 Show Pony Pl., Damascus, MD 20872

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MT. Zion Cemetery	11/24/01	Brookeville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
George R. Snowden	SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Respiratory Failure	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Congestive Heart Disease	
	Due to (or as a consequence of): c. Hypertensive Cardiovascular Disease	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus, insulin dependent

Multiple Cerebrovascular Accidents

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier	29c. License number	29d. Date signed (Month, Day, Year)
Alan Segal	D52261	Nov. 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type/Print)

Alan Segal, M.D. 1299 Lamberton Dr., Silver Spring, MD 20902

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	Donna G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 38856

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
CHARLES LATRELL JONES, JR.	NOVEMBER 15, 2001	7:13 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HOLY CROSS HOSPITAL	SILVER SPRING	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
419-09-4135	XX 1 M 2 F	82 Yrs.			JUNE 14, 1919	ALABAMA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	MONTGOMERY	WHEATON	1 Yes 2 XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11813 GALT AVENUE	20902	UNITED STATES OF AMERICA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 XX Married 3 Widowed 4 Divorced	XX Yes 2 No If Yes, Give Year or Dates: WWII	1 Yes 2 XX No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	DISTRICT SALES MANAGER	MIRRO CORPORATION

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CHARLES LATRELL JONES, SR.	LULA MAE MULL

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ANNELORE B. JONES (WIFE)	11813 GALT AVENUE; WHEATON, MARYLAND 20902

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	PARKLAWN MEMORIAL PARK	NOV. 19, 2001	ROCKVILLE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ Jim Schwartz

22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MARYLAND 20904-2891

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. HEART FAILURE	2 DAYS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. PERITONITIS	7 DAYS
	Due to (or as a consequence of):	
	c. PERFORATED SMALL INTESTINE	7 DAYS
	Due to (or as a consequence of):	
	d. CARCINOMA OF ILEUM	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the causa of death? 1 Yes XX 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes XX 2 No	1 Yes 2 No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 Yes 2 XX No	Hospital: XX 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
XX 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) XX 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Dwight R. Smith	D10642	NOVEMBER 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DWIGHT R. SMITH, M.D., 800 PERSHING DRIVE; SILVER SPRING, MARYLAND 20910

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	▶ Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 6

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 6+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38857

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Mildred	Kathleen	Bielaski Jett	November 17, 2001	12:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SHADY GROVE ADVENTIST HOSPITAL	ROCKVILLE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-50-9496	1☐ M 2☒ F	52 Yrs.			July 5, 1949	Washington, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Gaithersburg	Montgomery	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9243 Stewartown Road	20879	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joesph Leroy Bielaski	Agnes Mildred Spaulding

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Faith Jett/daughter	12430 Valleyside Way, Germantown, MD 20874

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Lakemont Cemetery	Nov 21, 2001	Davidsonville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Louis A. Sharp	Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Adenocarcinoma of Unknown Primary	months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D35635	November 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Kaplan, M.D. 18111 Prince Philip Drive, #327 Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	G. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. MEM

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

V

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38858

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JAMES JONES	NOV. 17 2001	7:20 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HERITAGE HARBOUR HEALTH & REHAB.	ANNAPOLIS	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
243-52-8776	1 X M 2 F	71 Yrs.			AUG. 10 1930	N. CAROLINA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	ANNAPOLIS	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3538 COHASSET AVENUE	21403	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 X Yes 2 No If Yes, Give Year or Dates: W,W,II	1 Yes 2 X No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4 or 5+)		
4th	0	HEAVY EQUIPMENT OPERATOR	CONSTRUCTION

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
EDMOND JONES	MARY SAVAGE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ERMA JONES (WIFE)	3538 COHASSET AVE. ANNAPOLIS, MD. 21403

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	DANCY MEMORIAL CEMETERY	11/24/01	PRINCEVILLE, NC.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Larry G. Reese #0783	WM. REESE & SONS MMORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finat disease or condition resulting in death)	a. Cerebrovascular disease Due to (or as a consequence of):	2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hypertension Due to (or as a consequence of):	
	c. Probable Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Data of delivary Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pleural effusion, aortic aneurysm

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 3 Probably 4 X Unknown	1 Yes 2 X No	1 Yes 2 X No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 X Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D38958	11/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dajeet Singh Gielly 1413 Annapolis Road #106 Odenton MD 21113

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 26 2001	▶ Penny B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38859

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
OPAL JACKSON	11 / 24 / 01	0030 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Anne Arundel Medical	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
234-03-9380	1☐M 2☒F	82 Yrs.			June 9, 1919	W. Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Anne Arundel	Riva	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3312 Breckenridge Way	21140	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Proprietor	Food Market

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Waldo Jones	Lora Jordan

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Bryan Jackson / Son	3312 Breckenridge Way Riva, Md. 21140

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Lakemont Mem. Gardens	11-28-2001	Davidsonville, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ C Bryan Powell	John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	24 hrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Cerebrovascular Accident	8yrs
	Due to (or as a consequence of): c. Dementia	5yrs.
	Due to (or as a consequence of): d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D45925	11-24-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHUKWUEMEKA UFOMADU, MD Anne Arundel Medical Center Annapolis, MD 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 26 2001	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

01-6364-003
crn
Unknown 01-317

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar ELVIN JOHNSON

Certificate of Death

Reg. No. 2001 38860

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
ELVIN R. JOHNSON JR.	November 11, 2001	12:25 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Cloverleaf Business Park	Glen Burnie	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
443-86-9104	1☒M 2☐F	18 Yrs.			MAY 18 1983	OKLAHOMA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	GLEN BURNIE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
628 LEPRECHAUN LANE	21061	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11th	0	MECHANIC	JIFFY LUBE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ELVIN R. JOHNSON SR.	CHERYL BENNETT

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ELVIN R. JOHNSON,SR. (FATHER)	628 LEPRECHAUN LA. GLEN BURNIE, MD. 21061

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	JOHN WESLEY UM CHURCH CEMETERY	11/17/01	WATERBURY, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Larry D. Reese M00483	WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Gunshot Wounds

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent et time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☐No

28. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) at scene

27. Manner of Death 1☐Natural 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
11-11-01	0013 M	1☐Yes 2☒No	Subject Shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Cloverleaf business Park	Veterans highway Glen Burnie

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	O.C.M.E.	November 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 16 2001	Donna P Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend#4a, 11/20/2001, MEM, Mont. Co. **Certificate of Death** Reg. No. 2001 38861

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Data of Death Month / Day / Year	3. Time of Death
Stephen	Koomson	November 15, 2001	7:40 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
920 Good Hope ~~Drive~~ Road	SILVER SPRING	MONTGOMERY

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
099-40-5580	1 ☒ M 2 ☐ F	65 Yrs.			DEC 12, 1935	GHANA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	MONTGOMERY	SILVER SPRING	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
920 GOOD HOPE ROAD	20905	UNITE STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4 or 5+)		
	4	COMPUTER OPERATER	RETAIL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOHN KOOMSON	EFUA BOOSOM

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ESTHER KOOMSON (SPOUSE)	920 GOOD HOPE ROAD, SILVER SPRING MARYLAND 20905

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	GATE OF HEAVEN	DEC 8, 2001	SILVER SPRING, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME INC 11800 NEW HAMPSHIRE AVE, SILVER SPRING MD 20904

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CONVULSION DISORDER	10 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): ALCOHOLISM	30 years
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fatal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSIVE CARDIOVASCULAR DISEASE

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

28. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD.	D31326	NOVEMBER 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RICHARD B ASHBY MD., 12164 CENTRAL AVENUE, STE 223 BOWIE MARYLAND 20721

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	[signature] B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38862

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH KNOWLES Newman
2. Date of Death: Month 11 Day 19 Year 2001
3. Time of Death: 09:15 AM
4a. Facility Name (If not institution, give street and number): #4 CHADWICK TERRACE
4b. City, Town, or Location of Death: EASTON
4c. County of Death: TALBOT

Funeral Director

5. Social Security Number: 222-01-2725
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 19 1913
9. Birthplace (State or Foreign Country): DE

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: #4 CHADWICK TERRACE
10f. Zip Code: 21601
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): EXECUTIVE
16b. Kind of Business/Industry: COMMUNICATIONS

17. Father's Name (First, Middle, Last): JOSEPH NEWMAN
18. Mother's Name (First, Middle, Maiden Surname): MABEL BOWEN

19a. Informant's Name/Relationship (Type, Print): VIVIAN NEWMAN/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): #4 CHADWICK TERRACE, EASTON, MD 21601

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHESAPEAKE CREMATION CTR
Date: 11-20-01
20c. Location - City or Town, State: STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: Joseph M Ostrowski CFSP
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Joseph Knowles Newman
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. atherosclerotic heart disease — years

Due to (or as a consequence of):
b. Atrial fibrillation — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. congestive heart failure — years

Due to (or as a consequence of):
d. Chronic obstructive pulmonary disease — years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) William Hill Manor Cottage #4

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: SYED
29c. License number: D 0046020
29d. Date signed (Month, Day, Year): 11/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SYED I. ALI M.D. 506 IDLEWILD AVE EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001
32. Registrar's Signature: Sandra B. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended 23 a,b,c,11/21/01,LDB,DOR

Certificate of Death

Reg. No. 2001 38863

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Carroll Kunkel

2. Date of Death: Month Nov. Day 18 Year 2001

3. Time of Death: 0300

4a. Facility Name (If not institution, give street and number): 117 High Street

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 213-46-1784

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 6, 1945

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 117 High Street

10f. Zip Code: 21613

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1963-66

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): civil engineer

16b. Kind of Business/Industry: construction

17. Father's Name (First, Middle, Last): William Kunkel

18. Mother's Name (First, Middle, Maiden Surname): Irene Thomas

19a. Informant's Name/Relationship (Type, Print): Susan A. Kunkel - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 117 High Street, Cambridge, MD 21613

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hills Memorial Gardens

Date: 11/23

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Kenneth R Thomas Jr

22. Name and Address of Facility: Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. renal cell carcinoma ~~metastatic to brain and lung~~ — months

Due to (or as a consequence of):

b. ~~tobacco abuse~~ metastatic to brain and lung

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. tobacco abuse

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Gail C.S. Anderson MD

29c. License number: D45190

29d. Date signed (Month, Day, Year): 11/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gail C.S. Anderson, M.D., 100 E. Carroll St., Salisbury, MD 21801

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001

32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38864

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month Day Year	3. Tima of Death
CURTIS G. KNISELY, JR.	NOVEMBER 17, 2001	12:05A M

4a. Facility Nama (If not institution, give street and number)	4b. City, Town, or Location of Daath	4c. County of Death
Laurel Regional Hospital	Laurel	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplace (State or Foraign Country)
276-24-0568	1☒M 2☐F	80 Yrs.			Oct 16, 1921	Ohio

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Insida City Limits
Maryland	Montgomery	Silver Spring	1☐Yes 2☒No

10e. Street and Number	10f. Zip Coda	10g. Citizen of What Country?
12807 Two Farm Dr	20904	USA

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forces?	13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.)	14. Race - American Indian, Black, White, atc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Giva Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highast grade completed)		16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Engineer	Electrical

17. Father's Nama (First, Middle, Last)	18. Mother's Name (First, Middla, Maiden Surnama)
Curtis G. Knisely	Katherine Gribble

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
Christine Knisely/Daughter	15 Old Coach Rd, Athens, OH 45701

20a. Method of Disposition	20b. Place of Disposition (Name of cematary, crematory or othar place)	Data	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from Stata 4☐Donation 5☐Other (Specify)	Dover Burial Park	11/23/01	Dover, OH

21. Signature of Funeral Service Licensee	22. Nama and Address of Facility
▶ Alan J. Donnell	Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, complications thet ceused tha daeth. Do not antar tha moda of dying, such as cerdiac or raspiratory errest, shock, or heart failure. List only one ceusa on each lina.

		Approximeta Intarval Between Onsel and Death
Immediata Cause (Final disease or condition resulting in death)	a. Sepsis	
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last	b. Due to (or as e consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the pasl 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal daath 3☐Ectopic pregnancy 4☐Pregnant at tima of death 5☐Othar (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

Renal insufficiency

Hypertension

23a. Did tobacco usa contribute to tha causa of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was en autopsy performed?	24b. Ware autopsy findings available prior to compiation of ceusa ol daath?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was cese refarred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Homa 5☐Rasidance 6☐Othar (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)			28f. Location (Street and Numbar or Rural Route Number, City or Town, Stata)

29a. Cartifier (Check only one) 1☒ **Certifying Physician:** To tha best of my knowledga, death occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated.
2☐ **Medical Examiner:** On tha basis of axaminetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Data signed (Month, Day, Yaar)
▶ P Boyle MD Attending.	D42580	November 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Parmjit Singh Aujla, MD 5632 Annapolis Rd, Ste. 13, Bladensburg, MD 20710

State Registrar

31. Data filed (Month, Day, Yaar)	32. Registrar's Signatura
NOV 19 2001	▶ Geneva G. Sparks

DHMH 17 Rav 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 38865

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Georgia Katherine Ketchersid

2. Date of Death (Month, Day, Year): November 14, 2001

3. Time of Death: 10:30 PM

4a. Facility Name (If not institution, give street and number): Mariner Health of Greater Laurel

4b. City, Town, or Location of Death: Prince George's

4c. County of Death: Laurel

Funeral Director

5. Social Security Number: 467-68-8769

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 14, 1913

9. Birthplace (State or Foreign Country): Quanah, TX

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 8903 Briardale Lane

10f. Zip Code: 20708

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Sanders Zack Bailey

18. Mother's Name (First, Middle, Maiden Surname): Effie Smith

19a. Informant's Name/Relationship (Type, Print): Earl Evans - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8903 Briardale Lane Laurel, MD 20708

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Big Valley | Date: 12/1/01

20c. Location - City or Town, State: Medicine Mound, TX

21. Signature of Funeral Service Licensee: Dennis Gilmore

22. Name and Address of Facility: Capitol Funeral Service 7211 Lee Hwy. Falls Church, VA

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebral Infarct — 1 wk

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Bennett So MD

29c. License number: D54488

29d. Date signed (Month, Day, Year): 11-15-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bennett So, MD, 8317 Cherry Ln, Laurel, MD 20707

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38866

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Johana Curtin Kennedy
2. Date of Death (Month, Day, Year): November 16, 2001
3. Time of Death: 9:00 AM
4a. Facility Name (If not institution, give street and number): 15509 Prince Frederick Way
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 214-60-4636
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 16, 1915
9. Birthplace (State or Foreign Country): Ireland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 15509 Prince Frederick Way
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Catholic University

17. Father's Name (First, Middle, Last): Cornelius Curtin
18. Mother's Name (First, Middle, Maiden Surname): Ann Carmody

19a. Informent's Neme/Reletionship (Type, Print): Joseph A. Kennedy /
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 15509 Prince Frederick Way, Silver Spring, MD 20906

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Gate of Heaven Cemetery
Date: Nov 20, 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Robert E Ramsey
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Finat disease or condition resulting in death)
a. Myocardial Infarction — Immediate

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Last
b. Coronary Artery Disease — years

Due to (or as a consequence of):
c. Essential Hypertension — years

Due to (or as e consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease

Hypercholesterolemia

23b. Did tobacco uee contribute to the ceuse of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Burt MD
29c. License number: D 23958
29d. Date signed (Month, Day, Year): November 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Burt I. Feldman, MD 3305 N. Leisure World Blvd., Silver Spring, MD 20906

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38867

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Edward Frank Kacala, Jr.	Nov. 17, 2001	7:00 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
25 Lincoln Parkway	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-48-3023	1 ☒ M 2 ☐ F	55 Yrs.			Apr. 29, 1946	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Anne Arundel	Annapolis	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
25 Lincoln Parkway	21401	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Vietnam	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
	1	Systems Auditor	Banking

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Edward Frank Kacala, Sr.	Mary Margaret Ecker

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ann Renae Sharman/Daughter	25 Lincoln Parkway, Annapolis, MD 21401

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Glen Haven Cemetery	Nov. 20, 2001	Glen Burnie, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Thomas E. [illegible]	Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	4½ mos.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Othar (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 ☐ **Medical Examiner:** On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner atated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [illegible]	D31577	November 19, 2001

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Russell A. Palmer 1600 S Crain Highway Glen Burnie, Md. 21061

State Registrar

31) Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 21 2001	[illegible] D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38868

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
NAOMI	G.	KINARD	November	14	2001	1:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6 Randall Court	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-46-6046	1 ☐ M 2 ☒ F	74 Yrs.					May 13 1927	West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Annapolis	1 ☒ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6 Randall Court	21401	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Personal Secretary	U.S. Comptroller

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas J. Garlick	Constance Campbell

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Roy F. Kinard/husband	6 Randall Court Annapolis, MD 21401

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	St. Anne's Cemetery	11/20/01	Annapolis, MD

21. Signature of Funeral Service Licensee ▶ Todd E. Lilla

22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ovarian Cancer — Approximate Interval: 7 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D0055495	November 15 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mark D. Phillips MD 900 Bestgate Rd. Suite 303 Annapolis MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	▶ Geneva P Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38869

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Mary Lynch

2. Date of Death Month Day Year: November 21 2001

3. Time of Death: 1707 M

4a. Facility Name (If not institution, give street and number): Union Hospital

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 174-26-7205

8. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG. 19, 1932

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Elkton

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 135 Midland Drive

10f. Zip Coda: 21921

10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

18b. Kind of Business/Industry: In her own home

17. Father's Name (First, Middle, Last): Francis McGoldrick

18. Mother's Name (First, Middle, Maiden Surname): Marie Friel

19a. Informant's Name/Relationship (Type, Print): Edward J. Lynch, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5712-A Chason Ridge Drive, Fayetteville, NC 28314

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Valley Forge Memorial Gardens

Date: Nov. 26, 2001

20c. Location - City or Town, State: King of Prussia, PA

21. Signature of Funeral Service Licensee: James S. Hicks

22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat diseese or condition resulting in deeth)

a. Cardiac Stand Still

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Bleeding — 2 hrs

Due to (or as a consequence of):

c. Repair of abdominal aneurysm — 3 hrs

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnency 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown

23d. Data of delivary Month Day Year

Part II. **Other significant conditions** contnbuting to death but not resulting in the underlying cause given in Part I.

Carcinoma (R) lung

Pneumonia

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to comptetion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner es stated. 2☐Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) end manner steted.

29b. Signature and title of certifier: S. Ikeda

29c. License number: D-21578

29d. Date signed (Month, Day, Year): 11/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Satoshi Ikeda, M.D. 111 W. High St., Elkton, MD 21921

State Registrar

31. Date filed (Month, Day, Year): NOV 26 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38870

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lydia Frances Luckett

2. Date of Death (Month, Day, Year): November 19, 2001

3. Time of Death: 11:30 PM

4e. Facility Name (If not institution, give street and number): Sligo Creek Nursing & Rehab.

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220-48-1957

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct 5, 1910

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1922 Locust Grove Road

10f. Zip Code: 20910

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Taylor Jerome Wampler

18. Mother's Name (First, Middle, Maiden Surname): Lou Rena Welton

19a. Informant's Name/Relationship (Type, Print): Joan R. Medeiros / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11413 Staten Court, Germantown, MD 20876

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Fort Lincoln Cemetery

Date: Nov 23, 2001

20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: ▶ AnneMarie Parker

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiiure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 3 weeks

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: ▶ [signature]

29c. License number: D 31563

29d. Date signed (Month, Day, Year): November 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles N. Benner, MD 11251 Lockwood Drive, Silver Spring, MD 20901

State Registrar

31. Date filed (Month, Day, Year): NOV 23 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38871

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
ABE LONDON		November 16, 2001	3:30pm M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
Casey House	Rockville	Montgomery	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
337-07-5692	1 X M 2 F	82 Yrs.			June 13,1919	Illinois

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Brookeville	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2708 Owens Road	20833	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 X Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Collections Agent	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Nathan London	Leah Davidson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Janice Bergman / Daughter	2708 Owens Road, Brookeville, MD 20833

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Mt. Lebanon Cemetery	11/19/01	Adelphi, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Renal Failure	Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Sepsis	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 X No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D35635	November 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Kaplan, 18111 Prince Philip Drive, Olney , MD 20832

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 21 2001	▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38872

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rene N. Levy

2. Date of Death (Month, Day, Year): November 12, 2001

3. Time of Death: 3:29am

4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 092-16-2646

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT. 27, 1917

9. Birthplace (State or Foreign Country): Luxembourg

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 22 Court House Square Apt. 403

10f. Zip Code: 20850

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Year or Dates: 1942-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Real Estate Broker

16b. Kind of Business/Industry: Real Estate

17. Father's Name (First, Middle, Last): Silvan Levy

18. Mother's Name (First, Middle, Maiden Surname): Rosalie Kahn

19a. Informant's Name/Relationship (Type, Print): Paul G. Levy / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8172 Madrillon Court, Vienna, VA 22182

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park

Data: 11/15/01

20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Danzansky Goldberg Memorial Chapel, Inc, 1170 Rockville Pike, Rockville, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finat disease or condition resulting in death)

a. Acute Dysrhythmia — Minutes

Due to (or as a consequenca of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA. Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D53887

29d. Date signed (Month, Day, Year): November 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Orlee Panitch, MD 9901 Medical Center Drive, Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38873

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month Day Year	3. Time of Death
Joong Sil Lee	November 18, 2001	7:55 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
10250 Westlake Drive, #305	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
102-50-1992	1☐ M 2☒ F	69 Yrs.			Sep. 7,1932	Korea

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Insida City Limits
MD	Montgomery	Bethesda	1☐ Yas 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10250 Westlake Drive #305	20817	United states

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forcas?	13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.)	14. Raca - American Indian, Black, Whita, atc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yas, Giva Year or Datas:	1☐ Yas 2☒ No Specify:	Specify: Asian

15. Decedent's Education (Specify only highast grade completed)		16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)	18b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mothar's Nama (First, Middle, Maiden Surname)
Hun Kye Kyu	Soo Ja Yum

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code)
Dong Kwan Lee/Son	13518 Cedar Creek Lane , Silver Spring MD 20904

20a. Method of Disposition	20b. Placa of Disposition (Nama of cemafary, cramafory or othar placa)	Data	20c. Location - City or Town, Stata
1☐ Burial 2☒ Cremation 3☐ Removat from State 4☐ Donation 5☐ Other (Specify)	Metropolitan Cremetory	November 19,2001	Alexandria, Virginia

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Tracy L. Hurley	DeVol Funeral Home. 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona causa on aach lina.

		Approximate Interval Batwaen Onsat and Daath
Immediate Cause (Final disease or condition resulting in death)	a. LUNG CANCER	8 MONTHS
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Dua to (or as a consequence of):	
	c. Dua to (or as a consequence of):	
	d. Due to (or as a consequance of):	

tF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yas, outcoma of pregnancy	23d. Data of dativary
1☐ Yes 2☐ No 9☐ Unknown	1☐ Liva birth 2☐ Fatal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Othar (specify) _____ 9☐ Unknown	Month Day Year

Part ti. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23a. Did tobacco usa contributa to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to compiation of causa of death?
1☐ Yas 2☐ No 3☒ Probably 4☐ Unknown	1☐ Yas 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medicat examiner?	26. Place of Daath (Check only ona)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Homa 5☒ Rasidance 8☐ Othar (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yaar)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yas 2☐ No	

28a. Placa of Injury - At homa, farm, street, factory, offica building, atc. (Specify)	28f. Location (Straat and Numbar or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, date and placa, and dua to tha causa(s) and mannar as stated.
2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at tha tima, date and placa, and due to tha causa(s) and mannar stated.

29b. Signature and titla of certifier	29c. Licensa number	29d. Data signed (Month, Day, Year)
▶ George Sotos	D43083	November 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
George Sotos, M.D., 9707 Medical Center Drive, #300, Rockville MD 20850

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signatura
NOV 20 2001	▶ G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #8, 11/29/2001, BMW, Montg.Co. **Certificate of Death** Reg. No. 2001 38874

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
GOLLAPALLI	LAZARUS	NOVEMBER 16, 2001	10:45AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
WASHINGTON ADVENTIST	TAKOMA PARK	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
380-90-1920	1☒M 2☐F	77 Yrs.			~~JAN~~ DEC 27, 1924	INDIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	PRINCE GEORGES	ADELPHI	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1836 METZEROTT RD APT 608	20783	INDIA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	INDIAN Specify:

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
*		SECURITY GUARD	HOSPITAL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
DAVID GOLLAPALLI	SARAMMA OGURA

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JULIAMMA LAZARUS (SPOUSE)	1836 METZEROTT ROAD APT 608, ADELPHI MARYLAND 20783

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	GEORGE WASHINGTON	11-19-01	ADELPHI, MARYLAND

21. Signature of Funeral Service Licensee: Raisa Gutierrez

22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME INC 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARDIOPULMONARY ARREST	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. CORONARY ARTERY DISEASE	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- CONGESTIVE HEART FAILURE
- DIABETES MELLITUS, HYPERTENSION
- STATUS POST: CEREBROVASCULAR ACCIDENT.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	26a. Date of Injury (Month, Day Year)	26b. Time of Injury	26c. Injury at Work?	26d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
R. Shyamsundar	D0053367	11.16.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rajan Shyamsundar, MD 10810 Darnestown Road, Suite: 202, Gaithersburg, MD: 20878.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	Geneva G. Sanks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMND ITEM#1 PER MD. G803 1-15-02 JAB

Certificate of Death

Reg. No. 2001 38875

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Jen-Yun	TAN	Lam	November	16,	2001	7:10 P.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SHADY GROVE ADVENTIST HOSPITAL	ROCKVILLE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
N/A	1☐M 2☒F	91 Yrs.					Feb. 12, 1910	China

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	North Potomac	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
14672 Brougham Way	20878	China

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Asian

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
UNKNOWN	UNKNOWN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary Cho/Daughter	14672 Brougham Way, North Potomac, MD. 20878

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Pine Lawn Mem. Park	11/23/2001	Pine Lawn, New York

21. Signature of Funeral Service Licensee: Michael Kleiman

22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Dr., Gaithersburg, MD. 20877

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. cerebro vascular accident	1 week
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
A. Mendhiratta MD	D38262	Nov 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR A. MENDHIRATTA 2401 Research BLVD Suite 340 Rockville MD 20850

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	Geneva G. Banks

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

To be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

Per telephone conversation 11-20-2001 with Earl Watson, Mr. Watson instructed to authorized me to white out date and restamp. Do not do that if to clean + legible in box 31. MEM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38876

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Marie Anna Lukitsch	Nov. 18, 2001	5:30 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
256 Finnegan Drive	Millersville	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
184-14-3370	1☐ M 2☒ F	80 Yrs.			Apr. 30, 1921	PA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Anne Arundel	Millersville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
256 Finnegan Drive	21108	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph McElhattan	Anna Frank

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Shirley Lukitsch/Daughter	256 Finnegan Drive, Millersville, MD 21108

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)	St. Mary's Cemetery	Nov. 23, 2001	Pittsburgh, PA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ James E. Barranco	Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic heart disease	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Cerebral Vascular disease.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

If FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☒ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Peter Ramirez MD	047157	November, 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PETER RAMIREZ MD 7845 OAKWOOD RD GLENBURNIE MD 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 21 2001	Geneva B Sparks

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar: Amend #1 per PHY AACO, Health KAH 11-20-01

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38877

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Russell	~~Loman~~	Lowman	November 9, 2001	2:30 A. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Chesapeake Hospice House	Linthicum	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-20-9603	1☒M 2☐F	72 Yrs.			Dec. 6, 1929	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Annapolis	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1613 Winchester Road	21401	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1946-1947	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Land Surveyor	Engineering/Surveying

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Russell Lowman	Esther Shannon

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
M. Patricia Mitchell-Lowman (wife)	1613 Winchester Rd. Annapolis, MD 21401

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Loudon Park Cemetery	11/13/2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Beverly M. Sailer	John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. GLIOBLASTOMA MULTIFORME	2 1/2 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Stuart Grossman MD	D23683	11/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
STUART GROSSMAN MD, JOHNS HOPKINS ONCOLOGY CENTER, BALTIMORE MD 21231

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	Brenda P Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38878

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Brendan Lawlor	November 12 2001	11:55 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Anne Arundel Medical Center	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
008-34-0179	1 [X] M 2 [ ] F	83 Yrs.			May 8, 1918	Vermont

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Crofton	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1735 Peartree Lane	21114	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Priest	Religion

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Lawlor	Bridgett Houlihan

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Morris Courchesne/nephew	1735 Peartree Lane Crofton, MD 21114

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	St. Charles Cemetery	11/17/01	Westminster, Vermont

21. Signature of Funeral Service Licensee: Todd E. Liller

22. Name and Address of Facility: John M. Taylor Funeral Home, 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia (probable aspiration) — Hours-Days

Due to (or as a consequence of):
b. Dementia — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown	23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prostate cancer

Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No	24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No	28. Place of Death (Check only one) Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 [ ] Yes 2 [ ] No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Alison A Bartfield MD	D0057824	Nov. 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ALISON A. BARTFIELD, M.D. 64 Franklin Street Annapolis MD 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	Jenna B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38879

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Troy Mullins

2. Date of Death (Month, Day, Year): November 20 2001

3. Time of Death: 7:37 AM

4a. Facility Name (If not institution, give street and number): 317 West Main Street

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 218-26-4867

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 28, 1934

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Elkton

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 317 West Main Street

10f. Zip Code: 21921

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1951-1955

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Estimator/Detailer

16b. Kind of Business/Industry: Electric Power Delivery

17. Father's Name (First, Middle, Last): William Harvey Mullins

18. Mother's Name (First, Middle, Maiden Surname): Viola Blankenship

19a. Informant's Name/Relationship (Type, Print): Barbara Mullins/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 317 West Main Street, Elkton, MD 21921

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bethel Cemetery

Date: NOV 23, 2001

20c. Location - City or Town, State: Chesapeake City, MD

21. Signature of Funeral Service Licensee: Donald S. Hicks

22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Colon Cancer — 9 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H. Farkas, MD

29c. License number: D15314

29d. Date signed (Month, Day, Year): Nov 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H Farkas MD VNA/Northern Chesapeake Hospice, Elkton, MD 21921

State Registrar

31. Date filed (Month, Day, Year): NOV 26 2001

32. Registrar's Signature: Donna D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

REPLACEMENT

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 01-38880

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Harry	Ray	Messick, Jr.	November	22	2001	09:51

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Union Hospital	Elkton	Cecil

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
221-20-7908	1 XX M 2 ☐ F	66 Yrs.					03/12/1935	PA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
DE	New Castle	Newark	1 ☐ Yes 2 XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
118 W. Tulip Lane	19713	USA

11. Meritel Stetus	12. Wes Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Detes:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	1 XX Yes 2 ☐ No 1953 - 1957	1 ☐ Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Owner/Operator	Property Rentals

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
Harry R. Messick, Sr.	Edna Foraker

19a. Informent's Name/Reletionship (Type, Print)	19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lois Messick - Wife	118 W. Tulip Lane, Newark, DE 19713

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1 XX Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify)	New London Pres. Cemetery	11/26/01	New London, PA

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
Spicer-Mullikin Funeral Homes, Inc.
1000 N. DuPont Pkwy., New Castle, DE 19720

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

		Approximete Interval Between Onset end Death
Immediete Cause (Finel diseese or condition resulting in deeth) a.	Sudden Severe Bradycardia	2 min.
Due to (or as a consequence of):		
Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	Severe Dilated Cardiomyopathy	~5 years
Due to (or as e consequence of):		
c.	Chronic Respiratory Insufficiency	>5 years
Due to (or as a consequence of):		
d.	Morbid Obesity	>5 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD, Anemia, Steroid Myopathy, Bronchitis,

Renal Insufficiency

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 XX Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 XX No	1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 X No	Hospitel: 1 XX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 XX Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	
	28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one)
1 XX **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) end menner as steted.
2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Dey, Year)
▶ Joseph C. Pennington, II	D0055342	December 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph C. Pennington, II MD H-42 Omega Dr., Newark, DE 19713

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signeture
DEC 13 2001	▶ [signature]

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38881

Murphy, Floyd

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FLOYD MURPHY

2. Date of Death (Month Day Year): Nov. 13 2001

3. Time of Death: 8:00PM

4a. Facility Name (If not institution, give street and number): DORCHESTER GENERAL HOSPITAL

4b. City, Town, or Location of Death: CAMBRIDGE

4c. County of Death: DORCHESTER

Funeral Director

5. Social Security Number: 425-62-3364

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct.13,1935

9. Birthplace (State or Foreign Country): Mississippi

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: DORCHESTER

10c. City, Town or Location: HURLOCK

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 329 PINE STREET, P.O.BOX 150

10f. Zip Code: 21643

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 3

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PICKLE DIPER

16b. Kind of Business/Industry: HARBER & BATMAN's PICKLE FACTORY

17. Father's Name (First, Middle, Last): JAMES MURPHY, SR.

18. Mother's Name (First, Middle, Maiden Surname): CARRIE WALTER

19a. Informant's Name/Relationship (Type, Print): NELLIE BERDAUX, FRIEND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 329 Pine St., P.O.Box150, Hurlock,Maryland 21643

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Federal Hill Cemetery

Date: 11/17/01

20c. Location - City or Town, State: Federalsburg,Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Bennie Smith Funeral Home 516 S. Main Street, Hurlock,Maryland 21643

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Profound Metabolic Acidosis	12 hrs
Due to (or as a consequence of): b.	(R) leg Arterial Embolism	12 hrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Congestive Heart Failure	7 days
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Small Bowel Obstruction

Seizure Disorder

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D26388

29d. Date signed (Month, Day, Year): NOV, 14 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Michael Fiddleman MD 302 Collins Ave Hurlock md 21643

State Registrar

31. Date filed (Month, Day, Year): NOV 19 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38882

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JEWELL YVONNE MURRY	NOV. 18, 2001	4:00 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Casey House	Rockville	MONTGOMERY

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-32-8122	1☐M 2☒F	65 Yrs.			Sept. 29, 1936	Maryland

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Monggomery	Germantown	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
19005 Queen's Cross Lane	20876	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th		Bus Attendant	Montg. Co. Schools

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Alfred Smith	Dorothy Diggs

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20876
Doretta Y. Hebron (Daughter)	19005 Queen's Cross Ln., Germantown, MD

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒1 Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Parklawn Mem. Park	11/27/01	Rockville, MD

21. Signature of Funeral Service Licensee: Laura L Snowden

22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Carcinoma	Months
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Endometrial Carcinoma	Years
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably ☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes ☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
☒1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Exeminer:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
E. P. Libre MD	D09470	Nov. 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
E.P. Libre, M.D. 10400 Connecticut Ave., Kensington, MD 20895

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Mary

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend#7, 11/20/2001, MEM, Montg.Co. **Certificate of Death** Reg. No. 2001 38883

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MICHAEL S. MORGAN
2. Date of Death (Month, Day, Year): NOV. 17, 2001
3. Time of Death: 10:20 PM
4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 217-44-9038
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): ~~55~~ 54 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr. 14, 1947
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3567 Whiskey Bottom Road
10f. Zip Code: 20707
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 68-70
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Groom
16b. Kind of Business/Industry: Racetrack

17. Father's Name (First, Middle, Last): Alexander Morgan, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Bertha Taylor

19a. Informant's Name/Relationship (Type, Print): Barbara Carter (Sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11327 Laurel Walk Dr., Laurel, MD 20708

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem. Park
Date: 11/23/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Frank R. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumocystis Carinii Pneumonia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Adult Immunodeficiency Syndrome
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one) Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William A. Warren MD
29c. License number: D13916
29d. Date signed (Month, Day, Year): Nov. 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William A. Warren, M.D. 321 Price George St., Laurel, MD 20707

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38884

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBERT GERARD MILLER
2. Date of Death Month Day Year: NOVEMBER 18 2001
3. Time of Death: 4:05 AM
4a. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 148-14-8460
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 30, 1925
9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Md.
10b. County: Montgomery
10c. City, Town or Location: Derwood
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5701 Dun Horse Lane
10f. Zip Code: 20855
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 6
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Statistician
16b. Kind of Business/Industry: Meteorology

17. Father's Name *(First, Middle, Last)*: Charles Gerard Miller
18. Mother's Name *(First, Middle, Maiden Surname)*: Elsie Schlagel

19a. Informant's Name/Relationship *(Type, Print)*: Anne C. Miller / Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5701 Dun Horse Lane, Derwood, Md. 20855

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holy Trinity Cemetery — Date: 11/21/01
20c. Location - City or Town, State: Bear Creek, PA.

21. Signature of Funeral Service Licensee: ▶ Muriel H. Barber
22. Name and Address of Facility: Muriel H. Barber Funeral Home, P. O. Box 5038, Laytonsville, Md. 20882

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PROGRESSIVE SHOCK — 2 DAYS
Due to (or as a consequence of):
b. SEPSIS — 5 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHOLECYSTECTOMY, DIABETES MELLITUS, RESPIRATORY FAILURE REQUIRING MECHANICAL VENTILATION, ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Steven Tilley
29c. License number: D36252
29d. Date signed *(Month, Day, Year)*: NOVEMBER 18, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEVEN T. KARIA, M.D. 11501 GEORGIA AVE SUITE 315, WHEATON MD 20902

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 21 2001
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38885

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
LOUIS MILLER	November 16, 2001	5:50 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4550 North Park Ave. #1006	Chevy Chase	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-01-9069	1 [X] M 2 [ ] F	88 Yrs.			Sept. 17, 1913	New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Chevy Chase	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4550 North Park Ave. #1006	20815	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Merchant Marine	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+) 4	Investor	Real Estate

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Morris Miller	Minnie Bregman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Geraldine Miller / Wife	4550 North Park Ave. #1006, Chevy Chase, MD 20815

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Judean Memorial Gardens	11/19/01	Olney, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Danzansky Goldberg Memorial Chapel, Inc 1170 Rockville Pike, Rockville, MD 20852

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic pancreatic cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Upper gastrointestinal bleed

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

If FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [/] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [/] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [/] No

26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [/] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [/] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Elizabeth P. Wheaton MD	DC 20256	11/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elizabeth P Wheaton MD 730 24th St NW DC 20037

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 21 2001	▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38886

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Edward Menas
2. Date of Death (Month, Day, Year): November 14, 2001
3. Time of Death: 9:10 AM
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 232-78-3797
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 53 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 2, 1948
9. Birthplace (State or Foreign Country): Farmington, WV

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Olney
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 17304 Guttenberg Court
10f. Zip Code: 20832
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: (Unavailable)
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Director of Strategic Policies
16b. Kind of Business/Industry: Dept. of Defence
17. Father's Name (First, Middle, Last): Matt Menas, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Eve Hudak
19a. Informant's Name/Relationship (Type, Print): Elizabeth W. Menas - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17304 Guttenberg Ct., Olney, MD 20832
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Carmel Cemetery
Date: Nov. 17, 2001
20c. Location - City or Town, State: Fairmont, WV
21. Signature of Funeral Service Licensee: Dennis Rittmaier
22. Name and Address of Facility: Ross Funeral Home 801 Fairmont Ave., Fairmont, WV 26554

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Leiomyosarcoma with Distant Mets — Approximate Interval Between Onset and Death: 1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Deep Venous Thrombosis — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d. — Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Wilhemina J. Ninala
29c. License number: D45285
29d. Date signed (Month, Day, Year): November 14, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WJ Ninala, 344 University Blvd #113, Silver Spring, Md 20901

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38887

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marjorie A. Meadows
2. Date of Death Month Day Year: November 20, 2001
3. Time of Death: 6:28 P M
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-48-7368
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 25, 1910
9. Birthplace *(State or Foreign Country)*: South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12903 Larkin Place
10f. Zip Code: 20853
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Date:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk
18b. Kind of Business/Industry: Clerical

17. Father's Name *(First, Middle, Last)*: Thomas Allen
18. Mother's Name *(First, Middle, Maiden Surname)*: Melinda Allen Robertson

19a. Informant's Name/Relationship *(Type, Print)*: Rose D. Noack/ Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12903 Larkin Place, Rockville, MD 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery — Date: Nov 26, 2001
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: Robert E Ramsey
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fatal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D50678
29d. Date signed *(Month, Day, Year)*: 11/21/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rajeev Batra, MD 11120 New Hampshire Avenue, Silver Spring, MD 20904

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 23 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38888

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alice Gertrude McMahon
2. Date of Death (Month, Day, Year): November 18, 2001
3. Time of Death: 6:00 PM

4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital Center
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 215-36-4846
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 21, 1913
9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Woodstock
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10375 Cavey Lane
10f. Zip Code: 21163
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: US Government

17. Father's Name (First, Middle, Last): E. Clarence Poston
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Agnes Healy

19a. Informant's Name/Relationship (Type, Print): Alice M. Bender / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10375 Cavey Lane, Woodstock, MD 21163

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: Nov 21, 2001
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: John L Clyde
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cardiac failure
Due to (or as a consequence of):
b. Coronary Heart Disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Atherosclerosis
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Parkinsons Disease, Pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: G Rath Attending Physician
29c. License number: D0012587
29d. Date signed (Month, Day, Year): 11-19-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): G.S. RATH, M.D. 7C CENNA CENTER, POST OFFICE RD. WALDORF MD. 20602

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

McMahon, Alice expired 11-18-01 @ 1800 Dr. Chan

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar Amend Item#10a-f per FHG804 2/20/02 EW

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38889

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Jarell Oneil McKinley	NOV. 13, 2001	9:46p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
none	1☒M 2☐F	0 Yrs.			Nov. 13, 2001	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
~~none~~ OR	Multnomah ~~none~~	~~none~~ Portland	1☒Yes ~~2☐No~~

10a. Street and Number	10f. Zip Code	10g. Citizen of What Country?
~~none~~ 117 N.E Stanton	~~none~~ 97212	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
0		none	none

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Cordell Anthony James McKinley	Leesha Posey

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Leesha Posey/ Mother	117 NE Stanton Portland, Oregon 97212

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Rose City Cem.	11/26/01	Portland, Oregon

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Philip D. Rinaldi	Philip D. Rinaldi Funeral Service 9241 Columbia Blvd. Silver Spring, Md 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. EXTREME PREMATURITY	30 MIN
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D20524	11/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Steven R. Wyner, MD, Holy Cross Hospital, 1500 Forest Glen Rd, Silver Spring, MD 20910

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 21 2001	▶ Geneva B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification; To Be Completed by Physician/Medical Examiner

3

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg No. 2001 38890

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Anita N. Marsh	November 18, 2001	2:20 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Montgomery General Hospital	Olney	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-76-0694	1☐M 2☒F	46 Yrs.			Nov. 13, 1955	Washington D.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Montgomery	Gaithersburg	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7501 Elioak Terrace	20879	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Secretary	Accounting

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Nathaniel Harris	Bernice "Unknown"

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Anthony Marsh Sr. (Husband)	7501 Elioak Terrace Gaithersburg, Md. 20879

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place) / Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metropolitan Crematory Nov. 21, 2001	Alexandria, Va.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Curtis E Day	DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disaase or condition resulting in death)	a. Acute Myocardial Infarction	1day
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Cardiogenic Shock	1day
	c. Due to (or as a consequence of): Anoxic Brain Encephalopathy	1day
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivary Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D51908	November 18 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David J Magliano 19101 Prince Phillip Drive Olney Maryland

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 23 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38891

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John M. Musterman

2. Date of Death: Month November Day 22 Year 2001

3. Time of Death: 7:22 P M

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 220-16-7764

8. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 3, 1926

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Davidsonville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 720 Appomattox Road

10f. Zip Code: 21035

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1946-72

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 4 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Colonel

18b. Kind of Business/Industry: U.S. Military

17. Father's Name (First, Middle, Last): John Henry Musterman

18. Mother's Name (First, Middle, Maiden Surname): Helen Elizabeth Litz

19a. Informant's Name/Relationship (Type, Print): Barbara A. Musterman/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 720 Appomattox Rd. Davidsonville, MD 21035

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Anne's Cemetery

Date: 11-26-01

20c. Location - City or Town, State: Annapolis, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. intracerebral hemorrhage — 1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D38445

29d. Date signed (Month, Day, Year): Nov 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ira Weinstein - 600 Rightly Ave Annapolis, MD

State Registrar

31. Date filed (Month, Day, Year): NOV 27 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg No. 2001 38892

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clarence Lawyer Marsh, Jr.

2. Date of Death: Month NOV Day 13 Year 2001

3. Time of Death: 2:43 AM

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 452-44-8601

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 25, 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Queen Anne

10c. City, Town or Location: Stevensville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 352 Wicomico Road

10f. Zip Code: 21666

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12):

College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Reviewer

16b. Kind of Business/Industry: Publisher

17. Father's Name (First, Middle, Last): Clarence L. Marsh

18. Mother's Name (First, Middle, Meiden Surname): Louise Swartz

19a. Informant's Name/Reletionship (Type, Print): Nancy Straight / sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 352 Wicomico Rd. Stevensville, Md. 21666

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Crematory

Date: 11-19-2001

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Brian Powell

22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. CARDIAC ARREST

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

Due to (or as e consequence of):

b. HYPOXEMIA — 12hrs.

Due to (or as a consequence of):

c. AIRWAY OBSTRUCTION — 12 hrs

Due to (or as a consequence of):

d.

Reviewed 11/14/01

IF FEMALE:

23b. Wes decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent et time of deeth 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [✓] Yes 2 [ ] No

28. Place of Death (Check only one)

Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [✓] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 11/12/2001

28b. Time of Injury: 8 PM

28c. Injury at Work? 1 [ ] Yes 2 [✓] No

28d. Describe how injury occurred: Choked on Steak

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State): Stevensville, MD

29a. Certifier (Check only one) 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: CBokhari

29c. License number: D26594

29d. Date signed (Month, Day, Year): NOV 13 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 64 Franklin St Annapolis MD 21401 Riaz Bokhari M.D.

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001

32. Registrar's Signature: Brenda D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 25a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38893

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Marguerite Gertrude McCann	Nov. 14, 2001	10:00 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1677 Pleasant Plains Road	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
495-42-0339	1☐ M 2☒ F	91 Yrs.			Jan. 10, 1910	MO

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Anne Arundel	Annapolis	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1677 Pleasant Plains Road	21401	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	High School Teacher	Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John McCann	Catherine Lynch

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
John Lademan/Nephew	1677 Pleasant Plains Road, Annapolis, MD 21401

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	St. Mary's Cemetery	Nov. 17, 2001	Annapolis, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
James E. Barranco	Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiopulmonary Arrest	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Myocardial Infarction	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

If FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D30741	Nov. 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffery Schmidlein, M.D., 844 Ritchie Hwy, Severna Park, MD 21146

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 16 2001	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38894

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN F. NABB
2. Dete of Death: Month Nov. Dey 24, Year 2001
3. Time of Death: 0800
4e Facility Name (If not institution, give street and number): Sunbridge Nursing and Rehabilitation
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Socisl Security Number: 221-14-6052
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthdey): 89 Yrs. If Under 1 Yeer: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Year): 5-24-1912
9. Birthplace (Stete or Foreign Country): Delaware

Usuel Residence of Decedent

10a. Stete: Delaware
10b. County: New Castle
10c. City, Town or Location: Middletown
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street and Number: 20 Holly Square
10f. Zip Code: 19709
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Neme (First, Middle, Last): Roy B. Zacheis
18. Mother's Neme (First, Middle, Meiden Surneme): Jenny Lorgan

19a. Informant's Neme/Reletionship (Type, Print): Ellen Van Culin-daughter
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 34263 Maryline Rd.Galena, Md.21635

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Townsend Cemetery
Dete: 11-28-01
20c. Location - City or Town, State: Townsend,DE.

21. Signeture of Funeral Service Licensee: Robert C. Hutchison
22. Neme end Address of Feciility: DANIELS & HUTCHISON 212 N. Broad st.,Middletown,DE.19709

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert feilure. List only one cause on each line. — Approximete Interval Between Onset and Deeth

Immediete Cause (Finel disease or condition resulting in deeth)
a. CAD
Due to (or as e consequence of):
b. presumed Myocardial infarction
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

Pert II. **Other significant conditions** contributing to death but not resulting in the undertying cause given in Pert I.
SEVERE ALZ DZ

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy pertormed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of exemineticn and/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and menner steted.

29b. Signeture and Iitle of certifier: Hom
29c. License number: D54073
29d. Dete signed (Month, Dey, Yeer): 26 NOV 01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Arlen Stone, 1817 Churchman's Center,New Churchmans Rd. Ext.New Castle,DE. 19720

State Registrar

31. Dete filed (Month, Dey, Yeer): NOV 27 2001
32. Registrer's Signeture: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38895

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Helen Cloward Nelsen	November 14, 2001	9:20 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3651 S. Leisure World Blvd, #1-D	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
528-01-7034	1☐ M 2☒ F	88 Yrs.			May 16, 1913	Utah

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3651 S. Leisure World Blvd, #1-D	20906	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Clerk	NASA

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Lewis Lynn Cloward	Flora Candland

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ruth E. Day/Friend	4 Tiffany Ct, Silver Spring, MD 20904

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Arlington National	Nov 27, 2001	Arlington, VA

21. Signature of Funeral Service Licensee: Hines-Rinaldi Funeral Home

22. Name and Address of Facility: 11800 New Hampshire Ave, Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Chronic Obstructive Pulmonary Disease	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Mark K. Li MD	D27865	November 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mark Li, M.D., 1721 University Boulevard, W; Wheaton, Maryland 20902

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	Geneva G. Smith

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38896

OMAN, Robert

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert Warren Oman

2. Date of Death Month: NOV Day: 12 Year: 2001

3. Time of Death: C:00 AM

4a. Facility Name *(If not institution, give street and number)*: UNIVERSITY Specialty Hospital

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 472-24-8099

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 1, 1928

9. Birthplace *(State or Foreign Country)*: Minnesota

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: DE

10b. County: Sussex

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 178 Palmetto Street Laurel Village

10f. Zip Code: 19956

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1946-47

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Gas & Oil Company

17. Father's Name *(First, Middle, Last)*: Carl Oman

18. Mother's Name *(First, Middle, Maiden Surname)*: Mildred Francis Oman

19a. Informant's Name/Relationship *(Type, Print)*: Marie E. Oman (Wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 178 Palmetto St. Laurel Village Laurel, DE 19956

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Laurel Hill Cemetery

Date: 11-16-01

20c. Location - City or Town, State: Laurel, Delaware

21. Signature of Funeral Service Licensee: Marcus A. Young

22. Name and Address of Facility: Short Funeral Home 700 West Street Laurel, DE 19956

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic Head and neck Carcinoma — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive Lung disease

Respiratory failure ventilator dependant

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D30494

29d. Date signed *(Month, Day, Year)*: 11/12/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): K Hashim University Specialty Hospital 611 South Charles St Baltimore MD 21230

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

M+/VA DQ

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 15 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38897

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
DAVID COTTER O'NEIL	November 22, 2001	12:45A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Civista Medical Center	La Plata	Charles

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
036-38-4018	1 [X] M 2 [ ] F	46 Yrs.			May 4, 1955	Rhode Island

To Be Completed by Funeral Director

Usual Residance of Decedant

10a. State	10b. County	10c. City, Town or Location	10d. Insida City Limits
RI	Providence	Lincoln	1 [X] Yas 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizan of Whet Country?
33 Wilbur Road	02865	USA

11. Marital Status	12. Was Decedant Evar in U.S. Armed Forcas?	13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.)	14. Race - Amarican Indian, Black, Whita, etc.
1 [ ] Navar Mamed 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Giva Yaar or Datas:	1 [ ] Yas 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highast grada complatad)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	Collega (1-4or 5+)	Materials Manager	Pen Company
	4		

17. Fathar's Nama (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William H. O'Neil,Jr.	Helen Cotter

19a. Informant's Name/Ralationshlp (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda)
Maureen O'Neil/Wife	33 Wilbur Road, Lincoln,Rhode Island 02865

20a. Method of Disposition	20b. Place of Disposition (Nama of cemetary, crematpry or other place) / Data	20c. Location - City or Town, Stata
1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)	Swan Point Cemetery 11/28/01	Providence,RI

21. Signatura of Funaral Sarvica Licansaa	M00945	22. Name and Addrass of Facility
David C. Echols		AREHART-ECHOLS FUNERAL HOME,P.A. P.O. BOX 567 LA PLATA,MD. 20646

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Entar tha diseasa, or complications that caused the death. Do not antar the moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on aach lina.

		Approximate Interval Batwaen Onset and Daath
Immediata Causa (Final disease or condition rasulting in daath)	Ischemic Heart Disease	
Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disaasa or injury that initiated events rasulting in daath) Last	a. Dua to (or es a consequence of):	
	b. Dua to (or as a consequence of):	
	c. Dua to (or as a consequance of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in tha past 12 months?	23c. If yes, outcoma of pragnancy	23d. Data of dalivary
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fatal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at tima of daath 5 [ ] Other (specify) _____ 9 [ ] Unknown	Month Day Year

Part II. **Other significant conditions** contributing to daath but not rasulting in tha underlying causa givan in Part I.

23a. Did tobacco usa contributa to tha causa of daath?	24a. Was an autopsy performed?	24b. Ware autopsy findings available prior to completion of cause of death?
1 [ ] Yas 2 [ ] No 3 [ ] Probably 4 [X] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yas 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only ona)	
1 [X] Yas 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Homa 5 [ ] Rasidance 6 [ ] Othar (Specify)

27. Manner of Daath	28a. Date of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding investigation 6 [ ] Could not be datarmined		M	1 [ ] Yas 2 [ ] No	

28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Routa Numbar, City or Town, State)

29a. Cartifiar (Check only one) 1 [ ] **Certifying Physician:** To tha bast of my knowledga, death occurred at the tima, date and place, and dua to tha causa(s) and mannar as stated.
2 [X] **Medical Examinar:** On tha basis of examination and/or invastigation, in my opinion, death occurred at tha tima, date and place, and due to tha causa(s) and mannar stated.

29b. Signatura and titla of cartifiar	29c. Licansa number	29d. Dete signed (Month, Day, Yaar)
Yahia M. Tagouri MD	D-50883	11-23-2001

30. Nama and addrass of person who complatad cause of death (Item 23a) (Type, Print)
Yahia M. Tagouri,MD 11655 Wine Sapp Place,La Plata,MD 20646

State Registrar

31. Data filed (Month, Day, Yaar)	32. Registrar's Signatura
NOV 27 2001	Donna B. Sparks

DHMH 17 Rav 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #19a, 11/23/2001, BMW, Montg. Co. **Certificate of Death**

2001 38898
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James F. O'Brien

2. Date of Death Month Day Year: November 15, 2001

3. Time of Death: 2:35 A M

4a. Facility Name (If not institution, give street and number): 12009 Wetherfield Lane

4b. City, Town, or Location of Death: Potomac

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 210-01-5068

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 18, 1919

9. Birthplace (State or Foreign Country): Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Potomac

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 12009 Wetherfield Lane

10f. Zip Code: 20854

10g. Citizen of What Country?: United States

11. Meritat Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: 1942- 1975

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12):

College (1-4or 5+): 5+

16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Administrative Officer

18b. Kind of Business/Industry: Veteran's Administration

17. Fether's Name (First, Middle, Last): John Frederick O'Brien

18. Mother's Neme (First, Middle, Meiden Surname): Theresa Mary De Temple

19a. Informent's Name/Reletionship (Type, Print): Marcelle ~~C.~~ M O'Brien/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12009 Wetherfield Lane Potomac, Maryland 20854

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removet from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cemetery

Dete: December 10, 2001

20c. Location - City or Town, Stete: Arlington, Virginia

21. Signeture of Funeral Service Licensee: George J. Kephart M00335

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Finet disease or condition resulting in deeth)

e. Hypoxemia — Weeks

Due to (or as e consequence of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last

b. Pulmonary Fibrosis — Years

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnent in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnency 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent et time of deeth 5 [ ] Other (specify) 9 [ ] Unknown

23d. Dete of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Atrial Fibrillation

23e. Did tobecco use contribute to the cause of deeth? 1 [ ] Yes 2 [ ] No 3 [ ] Probebly 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medicat exeminer? 1 [ ] Yes 2 [X] No

28. Place of Deeth (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end manner as steted. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and piece, and due to the cause(s) end manner stated.

29b. Signeture and title of certifier: Allen Roberts MD

29c. License number: 0101037516 (VA)

29d. Date signed (Month, Day, Year): November 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allen Roberts, M.D. National Naval Medical Center Bethesda, Maryland

State Registrar

31. Date filed (Month, Day, Year): NOV 19 2001

32. Registrar's Signature: Bonnie B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

2011

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended,#17,perF.H.,TCHD,10/15/01,sbb

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38899

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MILDRED E. PARROTT

2. Date of Death (Month, Day, Year): OCTOBER 10 2001

3. Time of Death: 6:45 AM

4a. Facility Name (If not institution, give street and number): TALBOT HOSPICE HOUSE

4b. City, Town, or Location of Death: EASTON

4c. County of Death: TALBOT

Funeral Director

5. Social Security Number: 220-12-1333

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 4 1920

9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: TALBOT

10c. City, Town or Location: EASTON

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 103 PARK LANE

10f. Zip Code: 21601

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CAFETERIA MANAGER

16b. Kind of Business/Industry: FOOD SERVICE

17. Father's Name (First, Middle, Last): ~~DAVID S. EBLING SR~~ Paul S. Ebling, Sr.

18. Mother's Name (First, Middle, Maiden Surname): LILLIE COHEE

19a. Informant's Name/Relationship (Type, Print): DAVID PARROTT/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7286 GLEN RIDGE RD., EASTON, MD 21601

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): SPRING HILL CEMETERY

Date: 10-13-01

20c. Location - City or Town, State: EASTON, MD

21. Signature of Funeral Service Licensee: Joseph M. Ostrowski CFSP

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON MD 21601

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lymphoma — Approximate Interval: 3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE HOUSE

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ludwig Egleseder III MD

29c. License number: D31466

29d. Date signed (Month, Day, Year): 10/10/01

30. Name and address of person who completed cause of death (Item 23d) (Type, Print): LUDWIG EGLESEDER III, M.D. 505 DUTCHMANS LANE EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year): OCT 11 2001

32. Registrar's Signature: Geneva G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38900

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Charles Proctor
2. Date of Death: Month Nov. Day 20, Year 2001
3. Time of Death: 10:30A M
4a. Facility Name (If not institution, give street and number): Civista Medical Center
4b. City, Town, or Location of Death: La Plata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 217-36-5638
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 63 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 13, 1938
9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Indian Head
10d. Inside City Limits: [X] Yes 2 [ ] No
10e. Street and Number: 106 Thompson Lane
10f. Zip Code: 20640
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chef
16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Joseph Hawkins
18. Mother's Name (First, Middle, Maiden Surname): Lillian Proctor

19a. Informant's Name/Relationship (Type, Print): Mary Christine Proctor Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 106 Thompson Lane, Indian Head, Md. 20640

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Charles Cemetery
Date: November 24, 2001
20c. Location - City or Town, State: Indian Head, Maryland

21. Signature of Funeral Service Licensee: M0668
22. Name and Address of Facility: Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. 20640

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Metastatic lung adenocarcinoma — Approximate Interval Between Onset and Death: years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b. Sepsis — week
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnent in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Data of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the causa of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A.M. Alikhani MD
29c. License number: D-0046046
29d. Date signed (Month, Day, Year): 11/20/01

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Amir A. Mirza Alikhani, MD 118 La Grange Ave P.O. Box 1890 La Plata, MD 20646

State Registrar

31. Date filed (Month, Day, Year): NOV 26 2001
32. Registrar's Signature: Geneva G. Foster

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Robert C. Proctor

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38901

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month Day Year	3. Time of Death
John William Proctor	November 21, 2001	11:53 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Daath	4c. County of Deeth
Fort Washington Hospital	Fort Washington	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplece (State or Foreign Country)
217-32-3000	1 [X] M 2 [ ] F	62 Yrs.			December 19, 1938	Washington, DC

Usual Residence of Decedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Insida City Limits
Maryland	Prince Georges	Oxon Hill	1 [X] Yas 2 [ ] No

10e. Street and Number	10f. Zip Coda	10g. Citizen of What Country?
1002 Shelby Drive	20745	USA

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forcas?	13. Wes Decedant of Hispanic Orlgin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.)	14. Race - Amarican Indian, Bleck, Whita, atc.
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	1 [ ] Yas 2 [X] No If Yes, Give Year or Datas:	1 [ ] Yas 2 [X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Truck Driver	Washington Suburban Sanitary Commission

17. Fether's Name (First, Middle, Last)	18. Mother's Neme (First, Middla, Maiden Sumame)
James A. Proctor	Agnes Proctor

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)
James A. Proctor Jr./Brother	11805 Maryland Point Road Nanjemoy, Maryland 20662

20a. Method of Disposition	20b. Place of Disposition (Nama of cematary, cramatory or othar place)	Data	20c. Location - City or Town, Stata
1 [X] Burial 2 [ ] Cremetion 3 [ ] Removet from Stata 4 [ ] Donation 5 [ ] Other (Specify)	Resurrection Cemetery	11/28/01	Clinton, Maryland

21. Signature of Funeral Service Licensee	22. Nema and Addrass of Facility
191	Adams Funeral Home P.A. Aquasco, Maryland

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only ona cause on each lina.

Approximate Intarvat Batwaen Onsat and Daath

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction

Dua to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. atherosclerotic heart disease

Dua to (or as a consequance of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcoma of pregnancy	23d. Data of dalivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Liva birth 2 [ ] Fatal daath 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of deeth 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23a. Did tobacco usa contributa to tha causa of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings availabla prior to comptation of causa of daath?
1 [ ] Yas 2 [✓] No	1 [ ] Yas 2 [ ] No

25. Was case referred to medical examiner?	28. Placa of Daath (Chack only ona)	
1 [✓] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA	Othar: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Othar (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)	28f. Location (Straat and Numbar or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one)

1 [✓] **Certifying Physician:** To tha best of my knowledga, daath occurrad at the tima, data and place, and dua to tha causa(s) and mannar as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at tha tima, data and piece, and due to tha causa(s) and mannar stated.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
James Mitchell MD	D0057632	November 24, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

James Mitchell MD Fort Washington Hospital Fort Washington Maryland 20744

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 27 2001	Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38902

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Geraldine Manning Pontious	November 15, 2001	5:35A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1109 McNeil Ln	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-12-7849	1 ☐ M 2 ☒ F	80 Yrs.			Dec 11, 1920	North Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1109 McNeil Ln	20905	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Sales Clerk	Retail

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Manning	Elizabeth Barber

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
George E. Pontious/Son	1109 McNeil Ln, Silver Spring, MD 20905

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	National Memorial Park	Nov 19	Falls Church, VA

21. Signature of Funeral Service Licensee: ▶ James F. Schwartz

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave, Silver Spring, MD 20904

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	3 Months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Stroke

23e. Did tobacco use contribute to the cause of death? ☒ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1 ☐ Yes ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ☒ 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Dawn Broderick	D45956	November 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dawn Broderick M.D 18109 Prince Philip Dr. Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	▶ Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38903

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Richard D. Pelicano
2. Date of Death (Month, Day, Year): November 13, 2001
3. Time of Death: 1:01 AM
4a. Facility Name *(If not institution, give street and number)*: Montgomery General
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-48-1668
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 101 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: January 21, 1900
9. Birthplace *(State or Foreign Country)*: Italy

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1 Pimlico Court
10f. Zip Code: 20906
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner
16b. Kind of Business/Industry: Gas Station

17. Father's Name *(First, Middle, Last)*: Not Available
18. Mother's Name *(First, Middle, Maiden Surname)*: Not Available

19a. Informant's Name/Relationship *(Type, Print)*: Margaret R. Billig / Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11280 Panorama Drive, New Market, Maryland 21774

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery — Date: Nov. 15 2001
20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: David E Carey. M00803
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Acute Renal Failure — 3 Days
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Generalized Arteriosclerosis
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Medical Doctor
29c. License number: D24543
29d. Date signed *(Month, Day, Year)*: November 19, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James A. Rossi, M.D. 3305 North Leisure World Blvd., Silver Spring, Maryland 20906

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 21 2001
32. Registrar's Signature: Geneva G. Scales

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38904

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KATHRYN FRANCES PAULHUS

2. Date of Death (Month, Day, Year): NOVEMBER 19 2001

3. Time of Death: 4:37 AM

4a. Facility Name (If not institution, give street and number): 18816 MUNCASTER ROAD

4b. City, Town, or Location of Death: DERWOOD

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 214-52-4319

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 20 1915

9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Md.

10b. County: Montgomery

10c. City, Town or Location: Derwood

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 18816 Muncaster Road

10f. Zip Code: 20855

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse

16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): John Swartz

18. Mother's Name (First, Middle, Maiden Surname): Barbara (Unknown)

19a. Informant's Name/Relationship (Type, Print): Kathryn P. Fain / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4716 Powder House Drive, Rockville, Md. 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Gate of Heaven Cemetery

Date: 11/23/01

20c. Location - City or Town, State: Silver Spring, Md.

21. Signature of Funeral Service Licensea: ▶ Muriel H. Barber

22. Name and Address of Facility: Muriel H. Barber Funeral Home, P. O. Box 5038, Laytonsville, Md. 20882

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or haart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finat disease or condition resulting in death)

a. Congestive Heart Failure — 2 Weeks

Due to (or as a consequence of):

b. Breast Cancer — 3 Years

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Hypertension — 12 Years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exeminetion and/or investigetion, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and mannar stated.

29b. Signatura and title of certifier: ▶ M Wajeed Khan MD

29c. License number: D32817

29d. Date signed (Month, Day, Year): November 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. WAJEED KHAN, M.D. 12016 GEORGIA AVE., WHEATON, MD. 20902

State Registrar

31. Data filed (Month, Day, Year): NOV 21 2001

32. Registrar's Signeture: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38905

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edith M. Parchment
2. Date of Death Month Day Year: November 19, 2001
3. Time of Death: 10:15 PM
4a. Facility Name *(If not institution, give street end number)*: Genesis Eldercare- Layhill Center
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 213-82-1597
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 90 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug 24, 1911
9. Birthplace *(State or Foreign Country)*: Jamaica

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Burtonsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 19 Crosswood Court
10f. Zip Code: 20866
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Milner
16b. Kind of Business/Industry: Self Employed

17. Father's Name *(First, Middle, Last)*: Richard M. Edwards
18. Mother's Name *(First, Middle, Maiden Surname)*: Sarah A. Rochester

19a. Informant's Name/Relationship *(Type, Print)*: Osborne C. Parchment / Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 16818 Excaliber Way, Sandy Spring, MD 20860

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery
Date: Nov 26, 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: John E. Parker
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular accident — Approximate Interval Between Onset and Death: 1week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Amendhiratta MD
29c. License number: D38262
29d. Date signed *(Month, Day, Year)*: Nov 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr A. MENDHIRATTA 2401 Research Blvd Suite 340 Rockville MD

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 21 2001
32. Registrar's Signature: Geneva G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38906

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leatha C. Price
2. Date of Death Month Dey Year: November 13, 2001
3. Time of Death: 12:34P M
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 219-14-0499
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 25, 1924
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Edgewater
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 1629 Fullerton Road
10f. Zip Code: 21037
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Personnel

17. Father's Name (First, Middle, Last): Charles Wesley Fries
18. Mother's Neme (First, Middle, Maiden Surname): Rosalie Agnes Raesler

19a. Informant's Name/Relationship (Type, Print): Donald E. Price/ Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1629 Fullerton Rd. Edgewater, MD 21037

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD Veterans Cemetery
Deta: 11-19-01
20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: [signature]
22. Neme and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ol dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis
Due to (or as a consequence of): b. urinary tract infection
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date ol delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary artery disease, myocardial infarction, End stage Parkinson's disease

23e. Did tobecco use contribute to the cause ol death? 1☐Yas 2☐No 3☐Probably 4☒Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐Yes 2☐No

25. Was case relerred to medical examiner? 1☐Yes 2☒No
28. Plece of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)
27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 8☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28l. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D41816
29d. Dete signed (Month, Day, Year): 11/13/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles W. Phelps MD Anne Arundel Medical Center 64 Franklin St. Annapolis MD 21401

State Registrar

31. Date filed (Month, Day, Year): NOV 15 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2001 38907

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
SARAH BATES RANDALL	November 23 2001	5:00am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Heartfields	Easton	Talbot

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
077-32-6279	1☐M 2☒F	93 Yrs.			Dec 29 1907	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Cecil	Earleville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
695 Knights Island Rd.	21919	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5	Supervisor Child Welfare	New York State Dept of Social Serv.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John P. Bates	Sadie I. Long

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sara R. Mullin (daughter)	P.O. Box 30 Georgetown, MD. 21930

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify)	Liberty Cemetery	11/29/01	Liberty, NY

21. Signature of Funeral Service Licensee: M00510

22. Name and Address of Facility: Galena Funeral Home of Stephen Schaech 118 West Cross St. Galena, MD. 21635

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. cryoglobulin anemia — years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Data of delivery
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant at time of deeth 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.
congestive heart failure

23e. Did tobecco use contribute to the cause of deeth?	24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) assisted living

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D25750	11/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROBERT B SANCHEZ 508 Idlewild Ave Easton, MD 21601

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 26 2001	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28c-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38908

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alexander Rybicki Jr.

2. Date of Death: Month November Day 21, Year 2001

3. Time of Death: 2215

4a. Facility Name (If not institution, give street and number): The Kent & Queen Anne's Hospital Inc.

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 221-20-4030

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 13 1935

9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: DE

10b. County: New Castle

10c. City, Town or Location: Wilmington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 701 South Broom St.

10f. Zip Code: 19805

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Medical Courier

16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): Alexander H. Rybicki

18. Mother's Name (First, Middle, Maiden Surname): Mary Ann Serwatka

19a. Informant's Name/Relationship (Type, Print): Carol Rybicki (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 701 S. Broom St. Wilmington, DE. 19805

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Kennedyville Cemetery

Date: 11/27/01

20c. Location - City or Town, State: Kennedyville, MD.

21. Signature of Funeral Service Licensee: M00510

22. Name and Address of Facility: John F. Yasik, Inc. 607 S. Harrison St. Wilmington, DE. 19805

Physician /Medical Examiner

23a. Part I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ruptured abdominal aortic aneurysm

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cardiorespiratory arrest

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gerard S. O'Conner MD

29c. License number: D0030368

29d. Date signed (Month, Day, Year): Nov. 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gerard S. O'Conner MD 100 Brown St. Chestertown, MD. 21620

State Registrar

31. Date filed (Month, Day, Year): NOV 26 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38909

Margaret Rodgers

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): MARGARET AURELIA RODGERS		2. Date of Death (Month, Day, Year): NOV. 23, 2001	3. Time of Death: 12:40P M
4a. Facility Name (If not institution, give street and number): Civista Medical Center	4b. City, Town, or Location of Death: La Plata	4c. County of Death: Charles	
5. Social Security Number: 579-42-0119	8. Sex: 1☐M 2☒F	7. Age (In yrs. last birthday): 79 Yrs.	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC.14,1921	9. Birthplace (State or Foreign Country): FLORIDA		

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	CHARLES	WALDORF	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3365 JUSTICE COURT	20602	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		SALES CLERK	HECHTS CO. RETAIL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
SPRAGUE O. FINLEY	DELIA COSTA

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SUSAN ROLLINS -- DAUGHTER	3895 OLD WASHINGTON RD. WALDORF,MD.20602

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	METROPOLITAN CREMATORY	11-27-01	ALEXANDRIA,VA.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
M00479 Michael O. Raymond	RAYMOND FUNERAL SERVICE,P.A. LA PLATA,MARYLAND 20646

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Third Degree Attrio Ventricular Block

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acute Myocardial Infarction

Due to (or as a consequence of):

c. Severe Coronary Artery Disease

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Data of delivery Month Dey Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Renal Failure

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown	24a. Was an autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No	26. Place of Death (Check only one) Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Song C. Chon M.D.	D37174	11/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Song C. Chon,MD 7C Post Office Rd. Waldorf, Maryland 20602

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 26 2001	Geneva G. Gaines

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38910

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
EDNA MAE ROBERTS	November 24, 2001	1:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
7122 Leonardtown Road	Bryantown	Charles

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-62-5292	1☐M 2☒F	81 Yrs.			January 3, 1920	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Charles	Bryantown	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7122 Leonardtown Road	20617	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Samuel Cooksey	Florence Murphy Cooksey

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William Roberts, Jr./Husband	P.O. Box 400 Bryantown, MD. 20617

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Old Fields Cemetery	11/27/01	Hughesville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
David C. Echols M00945	BRINSFIELD-ECHOLS FUNERAL HOME, P.A. P.O. BOX 128 CHARLOTTE HALL, MD. 20622

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Breast Cancer.	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Krishan Mathur	D28352	11-26-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur, MD PO Box 2729 LaPlata MD 20646

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 27 2001	Jenna G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38911

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Elizabeth Russell
2. Date of Death (Month, Day, Year): November 18, 2001
3. Time of Death: 5:00 PM
4a. Facility Name (If not institution, give street and number): 9 Sunnyside Road
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-48-9537
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 1, 1908
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9 Sunnyside Road
10f. Zip Code: 20910
10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Fiscal Officer
16b. Kind of Business/Industry: Carnegie Institution

17. Father's Name (First, Middle, Last): Carlton Russell
18. Mother's Name (First, Middle, Maiden Surname): Lillian Averill

19a. Informant's Name/Relationship (Type, Print): Louise Russell / Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9 Sunnyside Road, Silver Spring, MD 20910

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: Nov 19, 2001
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: Ken Stile
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Stroke — 3 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Smith S. Ho MD
29c. Licensa number: D 21900
29d. Date signed (Month, Day, Year): November 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Smith S. Ho, MD 7610 Carroll Ave., #280, Takoma Park, MD

State Registrar

31. Data filed (Month, Day, Year): NOV 21 2001
32. Registrar's Signature: Geneva G. Sanders

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 2001 38912

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Girard Hayden Rodgers
2. Date of Death (Month, Day, Year): November 16, 2001
3. Time of Death: 9:40 PM
4a. Facility Name (If not institution, give street and number): Mariner Health Care of Kensington
4b. City, Town, or Location of Death: Kensington
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 219-03-4198
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 29, 1914
9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: D.C.
10b. County: -
10c. City, Town or Location: Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6838 6th Street, N.W.
10f. Zip Code: 20012
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): - | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Marketing Representative
16b. Kind of Business/Industry: Natural Gas Company

17. Father's Name (First, Middle, Last): Arthur G. Rodgers
18. Mother's Name (First, Middle, Maiden Surname): Jeanette Rice

19a. Informant's Name/Relationship (Type, Print): Marion O. Rodgers/ Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6838 6th Street, N.W., Washington, D.C. 20012

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rock Creek Cemetery
Date: November 26, 2001
20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: [signature] M00689
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. Aspiration Pneumonia

Due to (or as a consequence of): Cerebrovascular Accident

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of): Hypertension

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Vinu Ganti
29c. License number: D41162 MD
29d. Date signed (Month, Day, Year): November 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vinu Ganti, M.D. 19529 Doctor's Drive, Germantown, Maryland 20874

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001
32. Registrar's Signature: [signature] Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 2001 38913

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THEODORE W. ROBINSON

2. Date of Death Month / Day / Year: NOV. 18, 2001

3. Time of Death: 2:16 AM

4a. Facility Name *(If not institution, give street and number)*: HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 358-16-4449

8. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: SEPT. 1, 1926

9. Birthplace *(State or Foreign Country)*: ILLINOIS

Usual Residence of Decedent

10a. State: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 9605 EVERGREEN ST.

10f. Zip Code: 20901

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yaar or Dates: 1943-1946

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: INSPECTOR

16b. Kind of Business/Industry: F.A.A.

17. Father's Name *(First, Middle, Last)*: THEODORE ROBINSON

18. Mother's Name *(First, Middle, Maiden Surname)*: MARY STEWART

19a. Informant's Name/Reletionship *(Type, Print)*: M. JOLEE ROBINSON/WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9605 EVERGREEN ST., SILVER SPRING, MD. 20901

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other placa)*: CHAMBERS CREMATORY

Date: 11/21/01

20c. Location - City or Town, State: RIVERDALE, MD.

21. Signeture of Funeral Service Licehsee: W.W. Chambers M00091

22. Name end Address of Fecility: 5801 CLEVELAND AVE. CHAMBERS FUNERAL HOMES,P.A., RIVERDALE, MD.20737

b

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one causa on each line.

Approximate Intervet Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Bronchopneumonia

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Malignant Lymphoma

Due to (or as a consequence of):

c. Acute Renal Failure

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yas 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [X] Neturei 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Placa of injury - At home, farm, atreet, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piace, end due to the cause(s) and mannar atated.

29b. Signature and title of certifier: Barry M. Rubin MD

29c. License number: D47499

29d. Date signed *(Month, Day, Year)*: 11-20-01

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Barry M. Rubin, MD 10801 Lockwood Drive #200 Silver Spring, MD 20901

State Registrar

31. Data filed *(Month, Day, Year)*: NOV 23 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

19+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38914

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Franklin James Richards

2. Date of Death: Month November Day 19 Year 2001

3. Time of Death: 7:58 P M

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-03-2488

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months ___ Days ___ If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): Nov 5, 1914

9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 ☐ Yes 2 X No

10e. Street and Number: 15320 Pine Orchard Drive

10f. Zip Code: 20906

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) ___ College (1-4or 5+) 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tariff Examiner

18b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Henry T. Richards

18. Mother's Name (First, Middle, Maiden Surname): Florence Brooks

19a. Informant's Name/Relationship (Type, Print): Esther Strem Richards/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15320 Pine Orchard Drive, Silver Spring, MD 20906

20a. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory 2001

Date: Nov 20,

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: Robert L Dyer

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Waldenstrom's Macroglobalinemia

Due to (or as a consequence of):

c. ___

Due to (or as a consequence of):

d. ___

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ___ 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pancytopenia

23a. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Peter B. Sherer MD

29c. License number: D 21910

29d. Date signed (Month, Day, Year): November 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter B. Sherer MD 3921 Ferrara Dr Wheaton, MD 20906

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38915

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joan Allison Rich
2. Date of Death (Month, Day, Year): November 19, 2001
3. Time of Death: 1:55 PM
4a. Facility Name (If not institution, give street and number): 11204 Buckwood Lane
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 212-80-7318
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 24, 1930
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11204 Buckwood Lane
10f. Zip Code: 20852
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): William Allison
18. Mother's Name (First, Middle, Maiden Surname): Marindy Greenwell

19a. Informant's Name/Relationship (Type, Print): Cynthia O'Neill / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11204 Buckwood Lane, Rockville, Maryland 20852

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.
Date: Nov. 21, 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Ray L. M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. Atherosclerotic cardiovascular disease — years
Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Patricia L. Tomsko, MD
29c. License number: D51916
29d. Date signed (Month, Day, Year): November 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patricia L. Tomsko, MD, 11140 Rockville Pike, PMB 348, Rockville, MD 20852

State Registrar

31. Date filed (Month, Dey, Yeer): NOV 23 2001
32. Registrar's Signature: Jennie G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 5 State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar PER FH G803 01/14/02 RR

Certificate of Death

Reg. No. 2001 38916

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Mary R. Rittershofer	November 16 2001	10:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1157 Tyler Aveune	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
~~212-03-0403~~ 212-05-0403	1☐ M 2☒ F	90 Yrs.			May 21, 1911	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Annapolis	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1157 Tyler Avenue	21403	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th		Chief Operator	Phone Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Horace Wells	Mamie Nicholson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary F. Ryon/niece	3521 Patuxent Road Huntingtown, MD 20639

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Epiphany Church Cemetery	11/21/01	Forestville, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Todd E. Miller	John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PANCREATIC CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

tF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnent at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of deeth? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D52245	November 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL R FREEDMAN MD 205 RIDGLEY AVENUE ANNAPOLIS, MARYLAND 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	▶ Benna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38917

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Winifred Kloman Rogers	November 12 2001	12:54 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Shady Grove Adventist Hospital	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-30-8724	1☐ M 2☒ F	82 Yrs.			February 6, 1919	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Gaithersburg	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
342 N. Summit Ave. #101	20877	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	1	Executive Secretary	US Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William C. Kloman	Leone S. Raff

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joy Pilpel/granddaughter	13416 Winterspoon Lane Germantown, MD 20874

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Baltimore Crematory	11/14/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Todd E. Lilley	John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis Syndrome	hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Urinary tract Infection	hours
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Liva birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnent at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Joseph A Ball	053317	11/12/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Joseph A. Ball 16220 Frederick Road #213 Gaithersburg, MD 20877

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	▶ Penny B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38918

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gertrude L. Rinehart
2. Date of Death (Month, Day, Year): November 13, 2001
3. Time of Death: 2:35 AM

4a. Facility Name *(If not institution, give street and number)*: St. Agnes Nursing and Rehabilitation Center
4b. City, Town, or Location of Death: Ellicott City
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 212-54-9062
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 22, 1911
9. Birthplace *(State or Foreign Country)*: South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8316 Governor Ridgely Lane
10f. Zip Code: 21043
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Sidney Ford
18. Mother's Name *(First, Middle, Maiden Surname)*: Della Widner

19a. Informant's Name/Relationship *(Type, Print)*: Robert Lee Rinehart/son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8316 Governor Ridgely Lane Ellicott City, MD 21043

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Glen Haven Cemetery
Date: 11/16/01
20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: ▶ Todd E. Lillon
22. Name and Address of Facility: John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebro Vascular Infarction — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Abeda Ali Khan M.D.
29c. License number: D 43323
29d. Date signed *(Month, Day, Year)*: Nov. 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Abeda Ali-Khan 10794 Hickory Ridge Road Columbia, MD 21044

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 19 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38919

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Viola Belle Simons
2. Date of Death: Month November Day 23rd Year 2001
3. Time of Death: 13:35 M
4a. Facility Name (If not institution, give street and number): Union Hospital of Cecil County
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 163-24-7864
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 27, 1930
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: North East
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 101 Cherry Street
10f. Zip Code: 21901
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Floor Lady
16b. Kind of Business/Industry: Department Store

17. Father's Name (First, Middle, Last): William Bonham
18. Mother's Name (First, Middle, Maiden Surname): Hazel Lee Dillow

19a. Informant's Name/Relationship (Type, Print): Susan L. Johnson/ Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 736 Rowland Road, Colora, Maryland 21917

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): North East Methodist
Date: November 26, 2001
20c. Location - City or Town, State: North East, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Crouch Funeral Home 127 South Main Street, North East, Maryland 21901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Pneumonia — Approximate Interval: 2 days

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnency: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Data of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive pulmonary disease

23e. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: [signature] Joshua M. Ramos, D.O.
29c. License number: D0047471
29d. Date signed (Month, Day, Year): November 23rd, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Suite 101 111 W. High Street Elkton Maryland 21921

State Registrar

31. Date filed (Month, Day, Year): NOV 26 2001
32. Registrar's Signature: [signature] Lakenda B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38920

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sterling Eugene Snyder

2. Date of Death (Month, Day, Year): November 20, 2001

3. Time of Death: 8:00 AM

4a. Facility Name (If not institution, give street and number): 280 Rock Church Road

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 180-07-9155

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 31, 1915

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Elkton

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 280 Rock Church Road

10f. Zip Code: 21921

10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dairy Farmer

16b. Kind of Business/Industry: Farming

17. Father's Name (First, Middle, Last): George Snyder

18. Mother's Name (First, Middle, Maiden Surname): Ida Becker

19a. Informant's Name/Relationship (Type, Print): Eugene V. Snyder/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 280 Rock Church Road, Elkton, Maryland 21921

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. John's Methodist Cem.

Date: Nov. 24, 2001

20c. Location - City or Town, State: Lewisville, PA

21. Signature of Funeral Service Licensee: Donna S. Hicks

22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Emphysema — Due to (or as a consequence of): — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H Farkas MD

29c. License number: D15314

29d. Date signed (Month, Day, Year): November 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H Farkas MD VNA-Northern Chesapeake Hospice, Elkton, MD

State Registrar

31. Date filed (Month, Day, Year): NOV 26 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38921

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Melvin Ignatius Smith, Sr.
2. Date of Death (Month, Day, Year): Nov. 16, 2001
3. Time of Death: 5:40PM
4a. Facility Name *(If not institution, give street and number)*: Civista Medical Center
4b. City, Town, or Location of Death: La Plata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 579-38-7425
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 12-02-1926
9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Bryans Road
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7340 Gabriel Drive
10f. Zip Code: 20616
10g. Citizen of Whet Country?: United States
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1945-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Paint Supervisor
18b. Kind of Business/Industry: D.C. Government
17. Father's Name *(First, Middle, Last)*: James C. Smith
18. Mother's Neme *(First, Middle, Meiden Surname)*: Martha Windsor
19a. Informant's Name/Relationship *(Type, Print)*: Patricia A. Smith/Wife
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 7340 Gabriel Drive,Bryans Road,Maryland20616
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: St. Charles Cemetery — Dete: 11-21-2001
20c. Location - City or Town, State: Indian Head, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Williams Funeral Home, P.A. M00668 4270 Hawthorne Road,Indian Head,Maryland 20640

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. large Bowel infarction
Due to (or as e consequence of):
b. Septic / cardiogenic Shock
Due to (or as e consequenca of):
c. myocardial infarction
Due to (or es e consequence of):
d.

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other *(specify)* 9 [ ] Unknown
23d. Dete of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of deeth? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Wes case referred to medicat examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, streel, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*
29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner es steted. 2 [ ] **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end manner stated.
29b. Signature and title of certifier: [signature] Abbas Omais M.D.
29c. License number: D-57708
29d. Date signed *(Month, Day, Yeer)*: November 17, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Abbas Omais,MD Cenna Medical Center 7C Post Office Rd Waldorf,MD 20602

State Registrar

31. Dete filed *(Month, Dey, Year)*: NOV 26 2001
32. Registrar's Signature: [signature] G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospitel or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or itame 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Melvin I. Smith

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38922

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PEARL JEANETTE SCHMITT

2. Date of Death (Month, Day, Year): November 23, 2001

3. Time of Death: 0230

4a. Facility Name (If not institution, give street and number): Fort Washington Hospital

4b. City, Town, or Location of Death: Fort Washington

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 226-64-7532

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG. 21, 1924

9. Birthplace (State or Foreign Country): WASHINGTON DC

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CHARLES

10c. City, Town or Location: INDIAN HEAD

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 87 RIVERSIDE RUN DRIVE

10f. Zip Code: 20640

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): BEARL M. GRIGSBY

18. Mother's Name (First, Middle, Meiden Surname): ETHEL MAY WATSON

19a. Informent's Name/Relationship (Type, Print): JOHN T. SCHMITT, JR. - SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 29079 HILL & DALE DRIVE, MECHANICSVILLE, MD 20659

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): THE HUNTT CREMATORY, NOV. 28, 2001

20c. Location - City or Town, State: WALDORF, MD

21. Signature of Funeral Service Licensee: MGB Mark G. Brohawn

MARK G. BROHAWN M00053

22. Name and Address of Facility: THE HUNTT FUNERAL HOME, INC. P.O.BOX 156, WALDORF, MARYLAND 20604

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in deeth): a. Atherosclerotic Cardiovascular Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☑ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, snd due to the cause(s) and manner stated.

29b. Signature and title of certifier: Salvador Sylvester DO

29c. License number: MD055927

29d. Date signed (Month, Day, Year): November 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Day, Year): NOV 26 2001

32. Registrar's Signature: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 38923

Frederick I Smith

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FREDERICK IGNATIUS SMITH,SR.
2. Data of Death Month Day Year: Nov. 23, 2001
3. Time of Death: 12:09P M
4a. Facility Name *(If not institution, give street and number)*: CIVISTA MEDICAL CENTER
4b. City, Town, or Location of Death: LA PLATA
4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 578-30-6859
8. Sex: 1 X M 2 ☐ F
7. Age *(In yrs. last birthday)*: 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: APR.1,1927
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CHARLES
10c. City, Town or Location: BEL ALTON
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 9265 CRAIN HWY. APT.102
10f. Zip Code: 20611
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4 or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: BUILDING INSPECTOR
18b. Kind of Business/Industry: U.S.GOVT.

17. Father's Name *(First, Middle, Last)*: CHARLES NICHOLAS SMITH
18. Mother's Name *(First, Middle, Maiden Surname)*: MARY EDNA LAWSON

19a. Informant's Name/Relationship *(Type, Print)*: CATHERINE KRAMER-DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 803A LARKSPUR COURT WALDORF,MD. 20602

20a. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: METROPOLITAN CREMATORY
Date: 11-27-01
20c. Location - City or Town, State: ALEXANDRIA,VA.

21. Signature of Funeral Service Licensee: M00479 Michael D. Raymond
22. Name and Address of Facility: RAYMOND FUNERAL SERVICE,P.A. LA PLATA,MARYLAND 20646

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Ventricular fibrillation — Minutes

Due to (or as a consequence of):
b. Emphysema — Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other *(specify)* 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Subendocardial myocardial infarction

23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

28. Place of Death *(Check only one)*: Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael Pimental DO
29c. License number: H-0042445
29d. Date signed *(Month, Day, Year)*: November 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael A. Pimental,DO 601 Post Office Rd Ste 1-a Waldorf,Md 20602

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 27 2001
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38924

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Herbert Sylvanus Slacum

2. Date of Death (Month, Day, Year): Nov. 19 2001

3. Time of Death: 0400

4a. Facility Name *(If not institution, give street and number)*: Chesapeake Woods Center

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 214-07-8656

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 26, 1913

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 113 Somerset Avenue

10f. Zip Code: 21613

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: accountant

16b. Kind of Business/Industry: food processing

17. Father's Name *(First, Middle, Last)*: Preston Slacum

18. Mother's Name *(First, Middle, Maiden Surname)*: Jenny Pierson

19a. Informant's Name/Relationship *(Type, Print)*: William E. Slacum - son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 119 Buena Vista Ave., Cambridge, MD 21613

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: East New Market Cemetery | Date: 11/24

20c. Location - City or Town, State: East New Market, MD

21. Signature of Funeral Service Licensee: John W. Thomas

22. Name and Address of Facility: Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not antar tha moda of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	1week
Due to (or as a consequence of):	b. Alzhamer's Dementia	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Eugene Naumier DO

29c. License number: H51793

29d. Date signed *(Month, Day, Year)*: 11/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eugene Naumier DO 503 Bym St Cambridge MD 21613

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 21 2001

32. Registrar's Signature: Donna G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38925

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Richard L. Smith	November 26, 2001	2:35 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3946 Honeysuckle Drive	Edgewater	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-24-2430	1 [X] M 2 [ ] F	79 Yrs.			June 28,1922	Mississippi

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Edgewater	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3946 Honeysuckle Drive	21037	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Musician	Music

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Lewis Smith	Jessie Williamson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jessie S. Halfpap/ Daughter	3946 Honeysuckle Drive Edgewater, MD 21037

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Metropolitan Crematory	11-26-01	Alexandria, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atrial Fibrillation 427.31 Imm

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertensive Cardiac w/Cong. Heart fail. 402.91 4yrs

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown	23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at tima of death 5 [ ] Other (specify) 9 [ ] Unknown	23d. Date ot delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cellulitis Torso 682.2 Legs 682.6.
Lumbar compression Fx 733.13

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No	24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No	26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 [ ] Yes 2 [ ] No	28d. Describe how injury occurred
1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examinar:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] , MD.	D000 1030	26NOV01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William H. Choate, M.D. 133 Defense Hwy., Suite 112, Annapolis, MD 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 27 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38926

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bertha Ann Stratton
2. Date of Death (Month, Day, Year): November 17, 2001
3. Time of Death: 5:50 PM
4a. Facility Name (If not institution, give street and number): 8422 10th Avenue
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 169-26-2817
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): July 4, 1931
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 8422 10th Avenue
10f. Zip Code: 20903
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, Whita, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Steven Smith
18. Mother's Name (First, Middle, Maiden Surname): Margaret Stefan

19a. Informant's Name/Reletionship (Type, Print): Susan Schoch / Daughter
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9515 Kingswood Court, Laurel, MD 20732

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: Nov 24, 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: ▶ AnneMarie Parker
22. Nama and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final diseese or condition resulting in death): a. Myocardial Infarction
Dua to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Hypertension
Due to (or as a consequence of):
c. Morbid Obesity
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was casa referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residance 6☐ Other (Specify)
27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner steted.
29b. Signature and title of certifier: ▶ [signature]
29c. Licansa number: DO 8307
29d. Date signed (Month, Day, Year): 11/19/01
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): DR TAKY MOURTZANAKIS 3450 Fort Meade Rd, Suite 109, Laurel MD 20724

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38927

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eva Ender Steinberg
2. Date of Death (Month, Day, Year): November 12, 2001
3. Time of Death: 2:12 AM
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 087-28-4057
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 6, 1904
9. Birthplace (State or Foreign Country): Russia

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 8100 Connecticut Ave., #710
10f. Zip Code: 20815
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Fether's Neme (First, Middle, Last): Samuel Klein
18. Mother's Neme (First, Middle, Maiden Surneme): Ida Schwartz

19a. Informant's Name/Relationship (Type, Print): Sheila Rogovin/ daughter
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3226 Volta Place, NW, Washington, DC 20007

20a. Method of Disposition: 1☒ Burlel 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): King David Mem. Gdns.
Date: Nov. 16, 2001
20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Neme and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line. (Approximate Interval Between Onset and Deeth)

Immediete Ceuse (Finei disease or condition resulting in deeth)
a. PNEUMONIA
Due to (or as a consequenca of):
b. CELLULITIS
Due to (or es a consequenca of):
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Last
c. DEMENTIA
Due to (or es e consequenca of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Piece of Deeth (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and plece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: ▶ [signature] M.D.
29c. License number: D-27660
29d. Date signed (Month, Day, Year): 11/12/01

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): ALANA GOSWAMI M.D. 11119 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001
32. Registrar's Signature: ▶ [signature]

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMND ITM#11&19a PR. INFMNT G802 12-11-01 JAB

1- For State Registrar Amend #27, 11/26/2001, BMW, MONIG.CO

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2001 38928

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month Day Year)	3. Time of Death
Emma V. St. Cyr	NOVEMBER 18 2001	2:55 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ST AGNES HOSPITAL	BALTIMORE	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
001-03-7263	1 ☐ M 2 ☒ F	90 Yrs.			May 8, 1911	West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Catonsville	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2114 Edmondson Avenue	21228	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
(Unknown) Shupenko	(Unknown)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dr. Wilfred J. St. Cyr (SON ~~Spouse~~)	2114 Edmondson Avenue Catonsville, MD 21228

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	St. Mary Cemetery	11/24/01	Claremont, NH

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Allen J. Woodall	Capitol Funeral Service, Inc. 7211 Lee Hwy Falls Church, VA

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. INTRACRANIAL BLEEDING	DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month Day Year)
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 ☒ No	Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	15624	NOVEMBER 18 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LAWRENCE OBER ST AGNES HOSPITAL, 900 CATON AVE, BALTIMORE MD 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Mary

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Emma V St Cyr

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38929

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Olga Spartales
2. Date of Death (Month, Day, Year): November 17, 2001
3. Time of Death: 9:55a M
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 028-14-3178
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 10, 1919
9. Birthplace (State or Foreign Country): Greece

Usual Residence of Decedent

10a. State: Md
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 5480 Wisconsin Avenue
10f. Zip Code: 20815
10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
18b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): John D. Spartales
18. Mother's Name (First, Middle, Maiden Surname): Mary Papadopoulos

19a. Informant's Name/Relationship (Type, Print): John Kalmer/Nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 623 Academy Street Newark, Delaware 19711

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Forest Hills Cem. Date: 11/21/01
20c. Location - City or Town, State: Boston, Mass.

21. Signature of Funeral Service Licensee: ▶ Nicki D Rinaldi
22. Name and Address of Facility: Philip D. Rinaldi Funeral Service 9241 Columbia Blvd. Silver Spring, Md 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Gastro intestinal hemorrhage — Approximate Interval Between Onset and Death: 24 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Aortic Stenosis
Coronary artery disease
Renal insufficiency

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown
24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No
28. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ N J Davenport
29c. License number: 41507
29d. Date signed (Month, Day, Year): 11/17/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nancy Davenport 3301 New Mexico Ave Wash DC

State Registrar

31. Date filed (Month, Day, Year): NOV 19 2001
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

OLGA SPARTALES 11/17/01 9:55AM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38930

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Dey Yeer	3. Time of Death
Earl	Charles	Silsby	November 17, 2001	2:00 PM

4a. Facility Name (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Death
Wilson Health Care Center	Gaithersburg	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yeer: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Dete of Birth (Month, Day, Year)	9. Birthplece (Stete or Foreign Country)
008-12-7373	1☒ M 2☐ F	79 Yrs.			Sept. 10, 1922	Vermont

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Gaithersburg	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
432 Russell Avenue	20877	United States

11. Merital Stetus	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Yeer or Detes: 1942-1946	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
	5+	Staff Member	Federal Government

17. Fether's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Silsby	Marian Suitor

19a. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Jonathan E. Silsby/Son	21 Ogden Avenue, White Plains, New York 10605

20a. Method of Disposition	20b. Plece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)	Parklawn Memorial Park	11/20/01	Rockville, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name end Address of Feclility: DeVol Funeral Home, 10 East Deer Park Dr., Gaithersburg, MD. 20877

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line.

		Approximete Interval Between Onset and Deeth
Immediete Cause (Finel diseese or condition resulting in death)	a. CEREBRAL AMYLOIDOSIS WITH VASCULITIS	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Wes cese referred to medical exeminer?	26. Plece of Death (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and mennar as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
▶ [signature]	D31563	NOVEMBER 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CHARLES M. BENNER MD 11251 LOCKWOOD DRIVE SILVER SPRING, MD 20901

State Registrar

31. Dete filed (Month, Dey, Yeer)	32. Registrar's Signeture
NOV 20 2001	▶ [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

12+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38931

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Raymond James Scopin, Sr.
2. Date of Death (Month, Day, Year): November 17, 2001
3. Time of Death: 3:50 AM
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 215-20-2928
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 16, 1926
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Wheaton
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1831 Arcola Avenue
10f. Zip Code: 20902
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1945-1947
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): unavailable; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner / Operator
16b. Kind of Business/Industry: Upholsterer

17. Father's Name *(First, Middle, Last)*: Joseph Anthony Scopin
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Alice Rivenbark

19a. Informant's Name/Relationship *(Type, Print)*: Margaret Scopin / Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1831 Arcola Avenue, Wheaton, MD 20902

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery
Date: Nov 21, 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: John L Chapski
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease

Due to (or as a consequence of):
b. Atherosclerosis with abdominal aortic aneurysm

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Hypertension

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Gastric carcinoma

Chronic Obstructive Pulmonary Disease

Partial small bowel obstruction

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lynne Diggs
29c. License number: D 34472
29d. Date signed *(Month, Day, Year)*: November 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lynne Diggs, MD 1500 Forest Glen Road, Silver Spring, MD 20910

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 19 2001
32. Registrar's Signature: G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

2 of 2

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38932

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Nasir Mohammad Sial

2. Date of Death Month Day Year: Nov. 19, 2001

3. Time of Death: 6:40 AM

4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 726-074-008

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 16,1924

9. Birthplace *(State or Foreign Country)*: Pakistan

Usual Residence of Decedent

10a. State: Canada

10b. County: Gloucester

10c. City, Town or Location: Ontario

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10a. Street and Number: 1872 Chaine Court

10f. Zip Code: KIC2N3

10g. Citizen of What Country?: Pakistan

11. Meritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 5

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Private Business

16b. Kind of Business/Industry: Chemical Engineer

17. Father's Name *(First, Middle, Last)*: Fateh Mohammad Sial

18. Mother's Name *(First, Middle, Maiden Surname)*: Hajra Begum

19a. Informant's Name/Relationship *(Type, Print)*: Zahir Ahmed -son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9920 New London Dr.,Potomac, Md. 20854

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rabwah Cemetery | Date: Nov.25, 2001

20c. Location - City or Town, State: Rabwah, Pakistan

21. Signeture of Funeral Service Licensee: James E. DeVol

22. Neme end Address of Facility: DeVol Funeral Home 2222 WIsconsin Ave.,NW.,Washington,D.C. 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finat disease or condition resulting in death) a.	Septic Shock	1 Day
Due to (or as a consequence of):	Adult Respiratory Distress Syndrome	2 weeks
Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.		
Due to (or as e consequence of): c.	Appendiceal Abscess	4 weeks
Due to (or as e consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Hepatocellular Cancer- Metastatic

Protein Malnutrition

Septic Shock

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1 [ ] Yes 2 [ ] No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Joseph R. Fontana, MD

29c. License number: 50718

29d. Dete signed *(Month, Day, Year)*: November 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph R. Fontana, M.D., 8600 Old Georgetown Road, Bethesda, Md. 20814

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 21 2001

32. Registrer's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38933

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LELAND SCHIFFNER
2. Date of Death (Month, Day, Year): NOVEMBER 19, 2001
3. Time of Death: 1:00 AM.
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 559-03-7460
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR. 23, 1913
9. Birthplace (State or Foreign Country): WASHINGTON

Usual Residence of Decedent

10a. State: CALIF.
10b. County: SACRAMENTO
10c. City, Town or Location: SACRAMENTO
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1508 42ND STREET
10f. Zip Code: 95819
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CONTRACTOR
16b. Kind of Business/Industry: PAINTING

17. Father's Name (First, Middle, Last): ABRAHAM SCHIFFNER
18. Mother's Name (First, Middle, Maiden Surname): MARY (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): RICHARD SCHIFFNER - SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 BRIGHTON LANE, GAITHERSBURG, MARYLAND 20877

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SACRAMENTO MEMORIAL LAWNS
Date: 11/21/01
20c. Location - City or Town, State: SACRAMENTO, CA.

21. Signature of Funeral Service Licensee: ▶ Nancy A. Pecanti
22. Name and Address of Facility: JOSEPH GAWLER'S SONS, INC. 5130 WISC. AVE. NW., WASHINGTON, D.C. 20016

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CONGESTIVE HEART FAILURE	1 WK
Due to (or as a consequence of):		
Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	SEPSIS	1 WK
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE LUNG DISEASE

CARDIAC ARRTHYMIA

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D 28656
29d. Date signed (Month, Day, Year): NOVEMBER 19, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): RAVI PASSI MD 15225 SHADY GROVE Rd. # 208, ROCKVILLE MD 20850

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

01-6396-003

mnmr

Frances Stansbury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38934

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Frances L. Stansbury	November 10, 2001	1310 pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1405 Sharps Point Road	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-05-0238	1☐M 2☒F	84 Yrs.			July 7, 1917	South Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Annapolis	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1405 Sharps Point Road	21401	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Weaverly C. Moore	Mallee B. Burdette

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Nancy R. Stansbury/daughter	1441 Pleasant Lake Road Annapolis, MD 21401

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	St. Margaret's Cemetery	11/17/01	Annapolis, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Todd E. Miller	John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, Maryland 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Data of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SCALP LACERATION

POLYCYTHEMIA VERA

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☑Yes 2☐No	1☑Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) at scene

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☑Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	FOUND 11-10-01	13.00 P M	1☐Yes 2☑No	SLIPPED FELL

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
AT HOME	1405 SHARPS POINT ANNAPOLIS, MD

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurrad at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signad (Month, Day, Year)
▶ [signature] MD	O.C.M.E.	November 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARYANN P. KOROL 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38935

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
MARGARET IDA THOMAS	NOV 17, 2001	17:53 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ER UPPER CHESAPEAKE MED CTR	BEL AIR	HARFORD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
197-36-6991	1☐M 2☒F	53 Yrs.			1/12/48	PA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
PA	Chester	Kelton	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
P.O. Box 38	19346	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		supervisor	education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William W. Thomas	Blanche Walker

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dawn Thomas/daughter	P.O. Box 38, Kelton, PA 19346

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Rolling Green Mem. Pk.	11/21/01	West Chester, PA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Edward Hall	Collins Funeral Home, 86 Pine St., Oxford, PA 19363

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HASCVD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHF

HYPERTHYROIDISM.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
GMS PRABHU MD	OCME	NOV 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GS PRABHU MD 728 BEL AIR NO BEL AIR MD 21014

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 21 2001	Barbara D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38936

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ralph Luther Thompson, Jr.	November 22, 2001	12:35 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Residence: 314 West Main Street	Rising Sun	Cecil

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-16-5222	1 [X] M 2 [ ] F	81 Yrs.			Dec. 1, 1919	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Cecil	Rising Sun	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
314 West Main Street	21911	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4 or 5+)		
Ten Years		Self Employed Farmer	Farming

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ralph Luther Thompson, Sr.	Helen Elizabeth Cullen

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Myrtle Kane Thompson (wife)	314 West Main Street, Rising Sun, Maryland 21911

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Angel Hill Cemetery	11/27/01	Havre de Grace, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Thomas M. Patterson, Sr.	Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARCINOMA OF LUNG WITH METASTASIS	1-2 MONTHS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. TO LUER - KIDNEY AND BONE	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown	23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown		
	24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No	24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No	26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 [ ] Yes 2 [ ] No	28d. Describe how injury occurred
	26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one)	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	▶ M.D	D44102	11/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William F. Renzulli, M.D., 901 Warburton Road, Rising Sun, Maryland 21911

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 26 2001	▶ Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38937

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lois Christeen Tolbert
2. Date of Death (Month, Day, Year): November 24, 2001
3. Time of Death: 0107
4a. Facility Name *(If not institution, give street and number)*: Calvert Manor Healthcare Center
4b. City, Town, or Location of Death: Rising Sun
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 235-30-3993
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 4, 1924
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Perryville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 522 Aiken Avenue
10f. Zip Code: 21903
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Twelve Years; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk
16b. Kind of Business/Industry: Canteen V.A.Medical Center Perry Point, Maryland

17. Father's Name *(First, Middle, Last)*: Chester Howard Close
18. Mother's Neme *(First, Middle, Maiden Sumeme)*: Monna Marie Allender

19a. Informant's Name/Relationship *(Type, Print)*: Timothy A. Tolbert (son)
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: P.O. Box 372, Perryville, Maryland 21903

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: Principio Cemetery
Date: 11/28/01
20c. Location - City or Town, Stata: Perryville,Maryland

21. Signature of Funeral Service Licensee: ▶ Thomas M. Patterson, Jr.
22. Name and Address of Facility: Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ALZHEIMERS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D42800
29d. Date signed *(Month, Dey, Year)*: 11/26/01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): T. Bivins MD, 314 S. Union Ave, Havre de Grace, Md 21078

State Registrar

31. Date filed *(Month, Dey, Year)*: NOV 26 2001
32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD
01-6664-017

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MICHAEL TODD

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38938

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MICHAEL ROSS TODD

2. Date of Death Month Day Year: NOVEMBER 23, 2001

3. Time of Death: 1:04P. M

4a. Facility Name *(If not institution, give street and number)*: CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death: LA PLATA

4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 438-76-8972

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 52 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: DEC. 30, 1948

9. Birthplace *(State or Foreign Country)*: LOUISIANNA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CHARLES

10c. City, Town or Location: WALDORF

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3404 RYON COURT

10f. Zip Code: 20601

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: VIETNAM

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SALESPERSON

18b. Kind of Business/Industry: RETAIL

17. Father's Name *(First, Middle, Last)*: EDGAR DELL TODD, SR.

18. Mother's Name *(First, Middle, Meiden Surname)*: EMMA LEE TATOM

19a. Informant's Name/Relationship *(Type, Print)*: TERESA TODD - SPOUSE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3404 RYON COURT WALDORF, MD. 20601

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: WALLACE MEMORIAL CEMETERY

Date: 11-30-01

20c. Location - City or Town, State: RAINELLE, W.VA

21. Signeture of Funeral Service Licensee: M00479 Michael O. Raymond

22. Name and Address of Facility: RAYMOND FUNERAL SERVICE LA PLATA, MARYLAND 20646

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE INJURIES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other *(specify)* 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*: 11-23-01

28b. Time of Injury: 1211 PM

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: STRUCK BY DRIVER OF CAR, OVERTURNED,

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: ROADWAY

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: RT 488 LA PLATA CHARLES CO MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marjorie McKell

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Yeer)*: NOVEMBER 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARGARITA D. KOROL MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 26 2001

32. Registrar's Signature: Jenna G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38939

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Frederick Howard Truitt	November 17, 2001	12:20 aM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
207 Church Street	Sharptown	Wicomico

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
221-16-8423	1[X] M 2[ ] F	92 Yrs.			Oct. 13, 1909	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Wicomico	Sharptown	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
207 Church Street	21861	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced	1[ ] Yes 2[X] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Minister	Methodist Conference

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Sampson Edward Truitt	Alice Powell Truitt

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary Virginia Truitt/ Wife	P.O. Box 63 Sharptown, MD 21861

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	Firemens Cemetery	11/20/2001	Sharptown, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	Short Funeral Home 13 E. Grove Street Delmar, DE 19940

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease — Years

Due to (or as a consequence of):
Atherosclerosis — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1[ ] Yes 2[ ] No 9[ ] Unknown	23c. If yes, outcome of pregnancy 1[ ] Live birth 2[ ] Fetel death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

24a. Was an autopsy performed? 1[ ] Yes 2[X] No	24b. Were autopsy findings available prior to completion of cause of death? 1[ ] Yes 2[ ] No

25. Was case referred to medical examiner? 1[ ] Yes 2[X] No	26. Place of Death (Check only one) Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA Other: 4[ ] Nursing Home 5[X] Residence 6[ ] Other (Specify)

27. Manner of Death 1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1[ ] Yes 2[ ] No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1[X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D36783	11/19/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jeffrey Etherton, M.D. P.R.M.C. Salisbury, MD 21804

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38940

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
ETHELYN	FLOREEN	THOMAS	November 10 2001	0857 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-82-8372	1☐ M 2☒ F	92 Yrs.			May 5,1909	Missouri

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Salisbury	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
511 Druid Hill Ave.	21804	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	1	Secretary	U.S. Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Grover Cleveland Riffie	Grace Lorena Nichols

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William O. Thomas/Husband	511 Druid Hill Ave., Salisbury, MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Salisbury Crematory	11/12/01	Salisbury, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ David H. Compson M01051	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Ventricular Fibrillation — minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Cardiomyopathy — years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☑ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown	1☐ Yes 2☐ No	1☐ Yes 2☑ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D36783	11/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jeffrey Etherton MD., PRMC, SALISBURY, MD.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 14 2001	▶ Penina G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

218-82-8372

Ethelyn Thomas

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38941

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John E Travers
2. Date of Death: Month 11 Day 10 Year 01
3. Time of Death: 5:25pm
4a. Facility Name (If not institution, give street and number): Waterview Health Care Center
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 217-28-2871
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February 24, 1932
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 105 Times Square
10f. Zip Code: 21801
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 — College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mentally Handicapped
16b. Kind of Business/Industry: None

17. Father's Name (First, Middle, Last): Arthur Travers
18. Mother's Name (First, Middle, Maiden Surname): Edna Simmons

19a. Informant's Name/Relationship (Type, Print): Elizabeth A. Neff/Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 415D Woodview Square, Salisbury, MD 21804

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Salisbury Crematory
Date: 11/13/01
20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: David A. Thompson MO1051
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Atherosclerotic Cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [✓] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mahesh Moondra
29c. License number: D32014
29d. Date signed (Month, Day, Year): 11/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MAHESH MOONDRA 106 MILFORD ST SUITE B SALISBURY MD 21804

State Registrar

31. Date filed (Month, Day, Year): NOV 14 2001
32. Registrar's Signature: Geneva G Sparks

1 DQ

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38942

MARCUS TWILLEY
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

4 DQ

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARCUS HOLLOWAY TWILLEY

2. Date of Death (Month, Day, Year): NOV. 10, 2001

3. Time of Death: 3:15 PM

4a. Facility Name (If not institution, give street and number): SALISBURY REHAB AND NURSING CENTER

4b. City, Town, or Location of Death: SALISBURY, MD.

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 217-36-0992

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 10, 1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1514 Riverside Dr., Apt. C211

10f. Zip Code: 21801

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces?: 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Rece - Americen Indien, Bieck, Whita, etc.: Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 9

College (1-4or 5+): –

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Farmer

16b. Kind of Business/Industry: Farming

17. Fether's Neme (First, Middle, Last): Claude A. Twilley

18. Mother's Neme (First, Middle, Meiden Surneme): Eliza Ellen Holloway

19e. Interment's Neme/Reletionship (Type, Print): Etta P. Twilley/Wife

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1514 Riverside Dr.,Apt.C211,Salisbury, MD

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Mardela Springs Cemetery

Date: 11/14/01

20c. Location - City or Town, State: Mardela Springs,MD

21. Signature of Funeral Service Licensee: David A. Thompson M01051

22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD21804

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset and Deeth

Immediate Cause (Finel diseese or condition resulting in death)
e. Coronary artery Disease years.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
b. Parkinson disease years.
Due to (or es e consequence of):
c. cerebral infarct 6 years
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uae contributa to the cauaa of death?: 1 [ ] Yaa 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes an autopsy performed?: 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings availeble prior to completion of cause of deeth?: 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?: 1 [ ] Yes 2 [X] No

26. Piece of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury: M

28c. Injury at Work?: 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one):
1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and manner es stated.
2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier

29c. License number: 029547

29d. Date signed (Month, Dey, Year): 11/12/01

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): WILLIAM ROBINS, M.D.,1104 HEALTHWAY DR.,SALISBURY,MD.21804

State Registrar

31. Date filed (Month, Dey, Year): NOV 14 2001

32. Registrar's Signature: Denise G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar: Amend #19B AA Co. Health Dept. AG 11-21-01

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38943

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY A. TAYLOR
2. Date of Death (Month, Day, Year): NOV. 13 2001
3. Time of Death: 1658 M
4a. Facility Name (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER
4b. City, Town, or Location of Death: ANNAPOLIS
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 212-42-3711
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 31 1943
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: ANNAPOLIS
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1315 McKINLEY STREET
10f. Zip Code: 21403
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10th
College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CUSTODIAN
16b. Kind of Business/Industry: STATE OF MARYLAND

17. Father's Name (First, Middle, Last): CHARLES CHASE
18. Mother's Name (First, Middle, Maiden Surname): ROSIE GREEN

19a. Informant's Name/Relationship (Type, Print): TONJU TAYLOR (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): ~~445 B COPELAND~~ 445 B Captains Circle Annap., MD 21401

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ANNAPOLIS MEMORIAL GARDENS
Date: 11/20/01
20c. Location - City or Town, State: ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee: Larry G. Reese MA00483
22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Acute myocardial infarction — Approximate Interval Between Onset and Death: 1hr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month / Day / Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Systemic lupus Erythematosus

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jack Lichtenstein
29c. License number: D068194
29d. Date signed (Month, Day, Year): 11/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jack Lichtenstein MD 207 Ridgely Ave Annapolis MD 21401

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001
32. Registrar's Signature: Donna P Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38944

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Edith M. Thomas	Nov	20	2001	1630

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
711 Tyler Ave.	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-03-0218	1☐M 2☒F	86 Yrs.			May 9, 1915	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
FL	Collier	Naples	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
168 E. Halo St.	34113	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Samuel Trice	Nora Marshall

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Judith Spates / daughter	711 Tyler Ave. Annapolis, Md. 21403

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Martin Church Cem.	12-1-2001	Martin, GA.

21. Signature of Funeral Service Licensee ▶ C Brian Powell

22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure — Hours

Due to (or as a consequence of):

b. Dementia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) daughter's home

27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ William P. Jones MD	D06054	11/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William P. Jones, MD 695 America 21035

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 26 2001	▶ Donna P Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar AA Co. Health Amend #12 ag 11-21-01

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38945

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ARTHUR THOMPSON

2. Date of Death: Month NOV. Day 9 Year 2001

3. Time of Death: 2:56 p M

4a. Facility Name (If not institution, give street and number): FUTURE CARE

4b. City, Town, or Location of Death: ARNOLD

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 219-12-2822

6. Sex: 1 M 2 F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 15 1923

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: CHURCHTON

10d. Inside City Limits: 1 Yes 2 No

10e. Street and Number: 5636 DEALE CHURCHTON ROAD

10f. Zip Code: 20733

10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1945-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8th

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER

16b. Kind of Business/Industry: SELF EMPLOYED

17. Father's Name (First, Middle, Last): JOHN H. THOMPSON

18. Mother's Name (First, Middle, Maiden Surname): MARY E. THOMPSON

19a. Informant's Name/Relationship (Type, Print): OLIVIA THOMPSON (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5636 DEALE CHURCHTON RD. CHURCHTON, MD. 20733

20a. Method of Disposition: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): LAKEMONT MEMORIAL GARDENS

Date: 11/14/01

20c. Location - City or Town, State: DAVIDSONVILLE, MD.

21. Signature of Funeral Service Licensee: Larry G. Reese #00483

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Chronic Renal Failure — 1 YR.

Due to (or as e consequence of):

b. Anemia — 1 YR.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events resulting in deeth) Last

Due to (or as a consequence of):

c. Gastrointestinal Bleed — 2 weeks

Due to (or as e consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Data of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D40519

29d. Date signed (Month, Day, Year): 11.13.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MIRZA M. NUSAIR 7845 OAKWOOD RD GLENBURNIE MD. 21061

State Registrar

31. Date filed (Month, Day, Year): NOV 16 2001

32. Registrar's Signature: B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2001 38946
Reg. No.

Amend#10d, 11/20/2001, MEM, Montg.Co.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Catherine	Tuross	November 15, 2001	7:35 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Home	Hyattsville	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
022-10-9087	1☐ M 2☒ F	87 Yrs.			Nov. 20, 1913	Boston, MA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George	College Park	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7305 Baylor Avenue	20740	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Patrick Norton	Cecelia Dolan

19a. Interment's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Noreen Tuross - Daughter	7305 Baylor Avenue College Park, MD 20740

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	St. Joseph Cemetery	11/19/01	Boston, MA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Allen L. Woodall	Capitol Funeral Service 7211 Lee Hwy Falls Church, VA

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Cerebrovascular Accident	2 weeks
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. End Stage Parkinson's Disease	4 years
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Osteoporosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Stg	D37934	11/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
S. Trifoglio MD 7500 Greenway Center Drive Greenbelt MD 20770

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. MEM

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38947

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gregory G. Turlik
2. Date of Death (Month, Day, Year): November 16, 2001
3. Time of Death: 1:30 PM
4a. Facility Name (If not institution, give street and number): 10000 Brunswick Avenue
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 219-54-9669
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 52 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 3, 1949
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10000 Brunswick Avenue
10f. Zip Code: 20910
10g. Citizen of What Country: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Social Worker
16b. Kind of Business/Industry: Municipal Government

17. Father's Name (First, Middle, Last): John A. Turlik
18. Mother's Name (First, Middle, Maiden Surname): Mary McDonnel

19a. Informant's Name/Relationship (Type, Print): Michael J. McCarthy/Confrere
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4409 Frederick Avenue, Baltimore, MD 21229

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cemetery | Date: Nov 20, 2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Eric S. Sterbo
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. Respiratory Failure
Due to (or as a consequence of):
b. Neuroacauthocytosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Martin S. Rusinowitz
29c. License number: D 33584
29d. Date signed (Month, Day, Year): November 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martin S. Rusinowitz, MD 1201 Seven Locks Road, Suite 101, Rockville, MD 20854

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001
32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38948

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MAUREEN A. THOMPSON
2. Date of Death: Month NOV. Day 16, Year 2001
3. Time of Death: 1:10 PM
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 213-40-9915
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 17, 1942
9. Birthplace (State or Foreign Country): PA.

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: TAKOMA PARK
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7330 PINEY BRANCH RD.
10f. Zip Code: 20912
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ATTORNEY
16b. Kind of Business/Industry: LAW

17. Father's Name (First, Middle, Last): CHARLES THOMPSON
18. Mother's Name (First, Middle, Maiden Surname): CATHERINE MURRAY

19a. Informant's Name/Relationship (Type, Print): JAMES WELU/HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 811 THAYER AVE. STE. 1, SILVER SPRING, MD. 20910

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): CHAMBERS CREMATORY
Date: 11/19/01
20c. Location - City or Town, State: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W. W. Chambers
MO0091
22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., 5801 CLEVELAND AVE. RIVERDALE, MD. 20737

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

b

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPTIC SHOCK
Due to (or as a consequence of):
b. MULTISYSTEM ORGAN FAILURE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. CARCINOMA OF LUNG
Due to (or as a consequence of):
d. METABOLIC ACIDOSIS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: LIVER METASTASES

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Vinu Ganti
29c. License number: D 41162
29d. Date signed (Month, Day, Year): Nov. 17, 2001

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VINU GANTI, M.D. 19529 DOCTORS DR., GERMANTOWN, MD. 20874

State Registrar

31. Date filed (Month, Day, Year): NOV 19 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38949

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carol Ann Thoma
2. Date of Death (Month, Dey, Yeer): November 20, 2001
3. Time of Death: 4:42PM
4e. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 214-54-1866
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 51 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 5, 1950
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11608 Idlewood Road
10f. Zip Code: 20906
10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elemenlery/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Public Schools

17. Fether's Neme (First, Middle, Last): Cecil Marshall
18. Mother's Name (First, Middle, Maiden Surname): Mary Alice Ward

19e. Informent's Neme/Reletionship (Type, Print): Thomas R. Thoma / Husband
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 11608 Idlewood Road, Silver Spring, Maryland 20906

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Plece of Disposition (Name of cemetery, cremetory or other place): Parklawn Memorial Park
Dete: Nov. 26, 2001
20c. Location - City or Town, Stete: Rockville, Maryland

21. Signature of Funerel Service Licensee: ▶ Andrew J. Cole
22. Neme end Address of Fecility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on eech line. (Approximete Interval Between Onset end Deeth)

Immediate Cause (Finel disease or condition resulting in deeth)
a. Cardio-respiratory Arrest
Due to (or es a consequence of):
b. Ventricular Fibrillation
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last
Due to (or es a consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Vascular Disease

Hypertension

High Cholesterol

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Nelurel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and menner steted.

29b. Signature end title of certifier: ▶ Shamima Abbas
29c. License number: D 45296
29d. Dete signed (Month, Day, Year): November 21, 2001

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): SHAMIMA ABBAS, MD 10810 Connecticut Avenue, Kensington, MD 20895

State Registrar

31. Dete filed (Month, Dey, Yeer): NOV 23 2001
32. Registrer's Signeture: Benna G. Sowell

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38950

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Emils W. Ulis	November 19, 2001	12:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-30-1002	1 X M 2 F	97 Yrs.			Nov 29, 1903	Latvia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
DC		Washington	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7509 8th Street, NW	20012	Latvia

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 X Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Manager	Dairy

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Indrikis Ulis	Ernestine Unknown

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rasma Kuplis / Daughter	6239 87th Avenue, New Carrollton, MD 20784

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Metropolitan Crematory 2001	Nov 20,	Alexandria, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Congestive Heart Failure	months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

Melanoma

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 3 Probably 4 X Unknown	1 Yes 2 X No	1 Yes 2 X No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D 28920 MD	11/19/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURINDER SINGH 7319A Hanover Parkway Greenbelt MD, 20770

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 21 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38951

Stephan L. Vaughan

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stephan Lee Vaughan
2. Date of Death (Month, Day, Year): Nov. 21, 2001
3. Time of Death: 3:35 p M
4a. Facility Name (If not institution, give street and number): Civista Medical Center
4b. City, Town, or Location of Death: Laplata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 152-44-6855
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 51 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): September 18, 1950
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Nanjemoy
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4121 Lucille Place
10f. Zip Code: 20662
10g. Citizan of Whet Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yes, Giva Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Alarm Installer
16b. Kind of Business/Industry: Alarm Company

17. Fathar's Nema (First, Middle, Last): Travis Lee Vaughan
18. Mother's Name (First, Middle, Maiden Sumama): Mary Ann Kahn

19a. Informant's Name/Relationship (Type, Print): Cheryl D. Danzey Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4121 Lucille Place, Nanjemoy, Md. 20662

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Placa of Disposition (Name of cemetary, cremetory or other place): Metropolitan Funeral Service
Date: November 29, 2001
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: M00668
22. Name and Address of Facility: Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. 20640

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked othar than "naturel", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Entar the diseesa, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line.

Immediate Causa (Final disease or condition rasulting in death): a. Acute Renal failure

Sequentially list conditions, if any, leading to immediete cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b. hepatitis c
Dua to (or as a consequenca of): c. alcohol abuse
Dua to (or as e consequence of): d.

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnent in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yas, outcoma of pregnancy: 1 [ ] Live birth 2 [ ] Fetal daath 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of daath 5 [ ] Othar (specify) 9 [ ] Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yas 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Wara autopsy findings availabla prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Wes case refarred to medicat examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, death occurred at tha time, data and place, and dua to tha causa(s) and manner stated.

29b. Signatura and title of certifier
29c. License number: D-45737
29d. Date signed (Month, Day, Year): 11/21/01

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): Nirmaladevi Gurvsamy, MD 6 Post Office Rd Ste 103 Waldorf, MD 20602

State Registrar

31. Date filed (Month, Day, Year): NOV 26 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38952

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Margaret M. Vickers	Nov. 19 2001	8:50 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Chesapeake FutureCare	Arnold	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-38-7177	1☐M 2☒F	86 Yrs.			Aug. 10, 1915	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	Anne Arundel	Annapolis	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
111 Chester Ave.	21403	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
5		Bottle Inspector	Pepsi Cola Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Douglas W. Duff	Annie Hicks

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mittie L. Keller / daughter	913 1/2 Windsor Ave. Annapolis, Md. 21403

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hillcrest Mem. Gardens	11-24-01	Annapolis, Md.

21. Signature of Funeral Service Licensee ▶ C Brian Powell

22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Advanced Alzheimer's dementia	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D-50725	11/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Riedinger 479 Jumpers Hole Severna Park, MD 21146

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 21 2001	Jeanne B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38953

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THOMAS LEE WELCH
2. Date of Death (Month, Day, Year): November 23, 2001
3. Time of Death: 6:00 A M
4a. Facility Name (If not institution, give street and number): 15025 Oaks Road
4b. City, Town, or Location of Death: Charlotte Hall
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 218-30-3074
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 65 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 20, 1935
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Charlotte Hall
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 15025 Oaks Road
10f. Zip Code: 20622
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No. If Yes, Give Year or Dates: 1958-60
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter
18b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): ARchie T. Welch
18. Mother's Name (First, Middle, Maiden Surname): Hazel L. Wenk

19a. Informant's Name/Relationship (Type, Print): Linda L. Welch - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15025 Oaks Road, Charlotte Hall, MD 20622

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans' Cem
Date: 11-29-01
20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: Mark G. Brohawn M00053
22. Name and Address of Facility: Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, Md 20604-0156

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CHRONIC RENAL FAILURE — YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
b. HYPERTENSIVE HEART DISEASE — YRS
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HYPERCHOLESTREMIA

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D-44436
29d. Date signed (Month, Day, Year): NOV 23 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ASHVINKUMAR J PATEL 102 Palmella CT #102 WALDORF MD

State Registrar

31. Date filed (Month, Day, Year): NOV 26 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38954

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PATRICIA ANN WILKERSON
2. Date of Death (Month, Day, Year): November 12 2001
3. Time of Death: 1328 M
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 214-46-3870
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 54 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/19/1947
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: DELAWARE
10b. County: SUSSEX
10c. City, Town or Location: MILLSBORO
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: Rt. 2 BOX 350 A
10f. Zip Code: 19966
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HUMAN RESOURCES WORKER
16b. Kind of Business/Industry: POULTRY

17. Father's Name (First, Middle, Last): RAYMOND RAE QUILLEN
18. Mother's Name (First, Middle, Maiden Surname): FRANCES HUDSON

19a. Informant's Name/Relationship (Type, Print): SANDRA L. CULP / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4854 LANGER LANE, WOODBRIDGE, VIRGINIA 22193

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): DEL. VETERANS CEM.
Date: 11/16/2001
20c. Location - City or Town, State: MILLSBORO, DELAWARE

21. Signature of Funeral Service Licensee: Richard T. Watson
22. Name and Address of Facility: WATSON FUNERAL HOME, INC., MILLSBORO, DELAWARE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Malignant Melanoma — Approximate Interval Between Onset and Death: 10 mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Geneva MD
29c. License number: D 20507
29d. Date signed (Month, Day, Year): 11/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph A. Grasso 145 E. Carroll St Salisbury MD

State Registrar

31. Date filed (Month, Day, Year): NOV 15 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

PATRICIA Wilkerson

PR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #8, 11/28/2001, EW, Montg. Co. **Certificate of Death** Reg. No. 2001 38955

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Martha Carolyn Wolfe
2. Date of Death (Month, Day, Year): November 19, 2001
3. Time of Death: 7:15pm
4a. Facility Name (If not institution, give street and number): Manor Care Bethesda
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: MOntgomery

Funeral Director

5. Social Security Number: 233-34-1368
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July ~~20~~ 2, 1920
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Md
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 13103 Turkey Branch Parkway
10f. Zip Code: 20853
10g. Citizen of What Country? USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Alexandria City Schools

17. Father's Name (First, Middle, Last): Ed Wolfe
18. Mother's Name (First, Middle, Maiden Surname): Lena Satterfield

19a. Informant's Name/Relationship (Type, Print): Carol Sue Edwards/Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13103 Turkey Branch Parkway, Rockville, Md 20853

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crem. Date: 11/20/01
20c. Location - City or Town, State: Alexandria, Va.

21. Signature of Funeral Service Licensee: Philip D. Rinaldi
22. Name and Address of Facility: Philip D. Rinaldi Funeral Service 9241 Columbia Blvd. Silver Spring, Md 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. ACUTE CARDIAC ARREST
Due to (or as a consequence of):
b. ADVANCED ALZHEIMERS DISEASE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Data of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Attan Kasid, MD Ph'D
29c. License number: D55054
29d. Date signed (Month, Day, Year): Nov. 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Attan Kasid, MD, PHD 17519 Redland Rd. Rockville, Md. 20855

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38956

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Elizabeth Morford Williams	November 17, 2001	6:45 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington Adventist Hospital	Takoma Park	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-18-4252	1☐M 2☒F	92 Yrs.			July 18, 1909	Connecticut

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
414 Hillmoor Drive	20901	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Administrative Assistant	Bank

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Jarratt Morford	Clara Combs

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Evie Williams /Daughter-in-law	115 Fairfield Drive, Catonsville, MD 21228

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Congressional Cemetery	Nov 20, 2001	Washington, DC

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert A. Lyon	Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	2 WEEKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D31563	NOVEMBER 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CHARLES M. BONNER MD 11251 LOCKWOOD DRIVE SILVER SPRING MD 20901

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	▶ [signature] G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38957

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Sloan Welton
2. Date of Death (Month, Day, Year): Nov. 17, 2001
3. Time of Death: 16:38
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 214-42-4588
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 22, 1934
9. Birthplace (State or Foreign Country): Moorefield, WV

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 10512 Farnham Dr.
10f. Zip Code: 20814-2222
10g. Citizen of What Country?: US

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Agriculture Economist
16b. Kind of Business/Industry: US Government

17. Father's Name (First, Middle, Last): Harry C. Welton, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Alma Pancake

19a. Informant's Name/Relationship (Type, Print): Helen Hale Welton / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10512 Farnham Drive, Bethesda, MD 20814-2222

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify):
20b. Place of Disposition (Name of cemetery, cremetory or other place): Olivet Cemetery — Date: 11/21
20c. Location - City or Town, State: Moorefield, WV

21. Signature of Funeral Service Licensee: [signature] 12/7/01
22. Name and Address of Facility: Elmore Funeral Home, 217 Winchester Ave, Moorefield, WV 26836

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CEREBELLAR GLIOBLASTOMA MULTIFORME	12 MOS.
Due to (or as a consequence of): b.	SEIZURE DISORDER	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: 0-23308
29d. Date signed (Month, Day, Year): NOV. 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VICTOR M. PRIEGO, MD 6410 ROCKLEDGE DR #625 BETHESDA MD 20817

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38958

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wilsie Sarah Ward

2. Date of Death: Month Nov. Day 20 Year 2001

3. Time of Death: 12:20 am

4a. Facility Name (If not institution, give street and number): Glasgow Nursing Home

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 213-22-9524

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 6 1913

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 311 Glenburn Avenue

10f. Zip Code: 21613

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Lorenzo Dow Wallace

18. Mother's Name (First, Middle, Maiden Surname): Della Meekins

19a. Informant's Name/Relationship (Type, Print): Arline Chase - great niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2934 Old Route 50, Cambridge, MD 21613

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Spedden Seward Cemetery

Date: 11/23

20c. Location - City or Town, State: Cambridge, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Mass — 3years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stroke with Right Hemiparesis

Organic Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Eugene Newmier DO

29c. License number: H51793

29d. Date signed (Month, Day, Year): 11/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eugene Newmier DO 503 Byrn St. Cambridge MD 21613

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38959

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jean Shirley Schugar Weiss
2. Date of Death Month Day Year: November 18, 2001
3. Time of Death: 11:15 AM
4a. Facility Name *(If not institution, give street and number)*: Shady Grove Nursing and Rehab Center
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 192-03-1036
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 90 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Mar. 8, 1911
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: FL
10b. County: Palm Beach
10c. City, Town or Location: Boca Raton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9300 S.W. 8th St.
10f. Zip Code: 33428
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Bookkeeper
16b. Kind of Business/Industry: Retail Grocery

17. Father's Name *(First, Middle, Last)*: Joseph Schugar
18. Mother's Name *(First, Middle, Maiden Surname)*: Frieda Amdur

19a. Informant's Name/Relationship *(Type, Print)*: Aileen W. Feldman/ daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3005 S. Leisure World Blvd., #205, Silver Spring, MD 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King David Mem. Gdns.
Date: Nov. 20, 2001
20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS — 1 MONTH

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PERIPHERAL VASCULAR DISEASE

DIABETES MELLITUS

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D 28656
29d. Date signed *(Month, Day, Year)*: NOVEMBER 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAVI PASSI, M.D. 15225 SHADY GROVE Rd. #208, ROCKVILLE, MD 20850

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 21 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38960

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bruce Watkins
2. Date of Death (Month, Day, Year): November 16, 2001
3. Time of Death: 4:30 PM
4a. Facility Name (If not institution, give street and number): Rockville Nursing Home
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-01-3881
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 10, 1910
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 303 Adclare Road
10f. Zip Code: 20850
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): UNK; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): UNK
16b. Kind of Business/Industry: UNK

17. Father's Name (First, Middle, Last): Frederick Louis Watkins
18. Mother's Name (First, Middle, Maiden Surname): Helena J. Springman

19a. Informant's Name/Relationship (Type, Print): Evelyn Thomason/Guardian
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11018 Marcliff Road, Rockville, MD 20852

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: Nov 20, 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Laura A Moody
22. Name and Address of Facility: Rapp Funeral & Cremation Services, 933 Gist Ave., Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrest
Due to (or as a consequence of):
b. Pneumonia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Dementia
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas V. Joseph
29c. License number: D47330
29d. Date signed (Month, Day, Year): Novemebr 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas Joseph, M.D. #50 W. Edmonston Drive, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year): NOV 20 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020 — To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, — Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38961

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Leona L. Walters	November 19, 2001	3:00 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Millennium at South River	Edgewater	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
235-18-8492	1☐M 2☒F	84 Yrs.			Apr. 24, 1917	West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Shady Side	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1509 Calloway Drive	20764	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Cashier	Department Store

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Isaac Stottlemire	Lillie Wright

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Clarence J. Layne/ Son	1509 Calloway Drive Shady Side, MD 20764

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metropolitan Crematory	11-19-01	Alexandria, VA

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility George P. Kalas Funeral Home
2973 Solomons Island Rd. Edgewater, MD 21037

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failura. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrythmia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Dua to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease

23a. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ [signature]

29c. License number D0057028

29d. Date signed (Month, Day, Year) 11-19-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ADITYA CHOPRA, M.D. 621 RIDGELY AVE. STE401 ANNAPOLIS, MD 21401

State Registrar

31. Date filed (Month, Day, Year) NOV 20 2001

32. Registrar's Signature [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38962

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
BRENDON DALE WOLFE	NOV 14 2001	8:20 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NATIONAL NAVAL MEDICAL CENTER	BETHESDA	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
none	1 [X] M 2 [ ] F	Yrs.	11		Nov 3, 2001	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	Laurel	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12 Riverview Court Apt 202	20707	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
none		none	none

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Richard Dale Wolfe Jr.	Annessa Jean Levenhagen

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Annessa Levenhagen - Mother	12 Riverview Court Apt 202 Laurel, MD 20707

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Swan Lake Mem Gardens	11/20/01	Michigan City, IN

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Ellen L. Woodall	Metropolitan Funeral Service 5517 Vine St Alexandria, VA

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. EXTREME PREMATURITY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Russell R. Moores MD	D-41551	11/14/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RUSSELL R. MOORES, COL, MC, USA

NATIONAL NAVAL MEDICAL CENTER
BETHESDA MD 20889-5600

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-I show any injury or other traumatic event, the Medical Examiner must be notified at once.** Mary

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38963

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JAMES LEWIS YATES	NOVEMBER 25, 2001	11:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
9185 KEECHLAND FARM ROAD	NEWBURG	CHARLES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-16-4730	1 [X] M 2 [ ] F	81 Yrs.			OCT. 16, 1920	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	CHARLES	NEWBURG	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9185 KEECHLAND FARM ROAD	20664	UNITED STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-1946	1 [ ] Yes 2 [X] No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
4TH GRADE		LABORER	FOOD SERVICE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
DANIEL YATES	AGNES THOMAS YATES

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARY E. YATES / WIFE	9185 KEECHLAND FARM ROAD, NEWBURG, MARYLAND 20664

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	MARYLAND VETERAN CEM.	11/29/2001	CHELTENHAM, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Lydia C. Thornton Johnson LYDIA C. THORNTON JOHNSON M00583	THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)

a. Prostate Cancer

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown	23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other (specify) 9 [ ] Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Rachel Thornton MD	MD. D37174	11/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7C POST OFFICE ROAD, WALDORF, MARYLAND 20602

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 27 2001	Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

James Lewis Yates

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38964

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virginia Elizabeth Yost

2. Date of Death (Month, Day, Year): November 18, 2001

3. Time of Death: 9:15 AM

4a. Facility Name (If not institution, give street and number): 22811 Ridge Road

4b. City, Town, or Location of Death: Germantown

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-36-3020

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 11, 1922

9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Germantown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 22811 Ridge Road

10f. Zip Code: 20876

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Cecil Ramsey Callis

18. Mother's Name (First, Middle, Maiden Surname): Alma Irene Taylor

19a. Informant's Name/Relationship (Type, Print): Edward E. Yost / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22811 Ridge Road, Germantown, MD 20876

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park

Date: Nov 21, 2001

20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: John E. Parker

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Transitional cell carcinoma of the Bladder years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph Kaplan MD

29c. License number: D 35635

29d. Date signed (Month, Day, Year): November 19, 2001

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Joseph Kaplan, MD 18111 Prince Philip Drive, Suite 327, Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year): NOV 21 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38965

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hong Yi
2. Date of Death (Month, Day, Year): Nov 17, 2001
3. Time of Death: 4:40PM
4a. Facility Name (If not institution, give street and number): Covien Nursing Home
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 182-58-3705
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN 7, 1937
9. Birthplace (State or Foreign Country): KOREA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 57 CATOCTIN CT
10f. Zip Code: 20906
10g. Citizen of What Country?: KOREA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: ASIAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SELF EMPLOYED
16b. Kind of Business/Industry: PRIVATE

17. Father's Name (First, Middle, Last): BONG HO YI
18. Mother's Name (First, Middle, Maiden Surname): YI SOON CHOI

19a. Informant's Name/Relationship (Type, Print): CHONG HWA YI/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 57 CATOCTIN CT, SILVER SPRING, MD 20906

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GEORGE WASHINGTON CEM
Date: 11/20/01
20c. Location - City or Town, State: ADELPHI, MD

21. Signature of Funeral Service Licensee: Dawn Bulmer
22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME 11800 NEW HAMPSHIRE AVE, SILVER SPRING, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	myocardial infarction	3 min
Due to (or as a consequence of): b.	coronary artery disease	5 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: renal failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gary Kaz
29c. License number: D41617
29d. Date signed (Month, Day, Year): Nov 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary Kazlow MD 10805 Hickory Ridge Rd Columbia MD 21044

State Registrar

31. Date filed (Month, Day, Year): NOV 19 2001
32. Registrar's Signature: Geneva G. Sanders

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38966

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Marvin David ZIMMERMAN	November 20, 2001	9:22 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
110-18-2705	1☒M 2☐F	75 Yrs.			Nov. 8, 1926	New York

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3005 S. Leisure World Blvd. #603	20906	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WWII	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Teacher/Principal	Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Jacob Benson Zimmerman	Henrietta Ruth Echenthal

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906
Natalie Zimmerman, Wife	3005 S. Leisure World Blvd. #603, Silver Spring, MD

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Judean Memorial Gardens	11/23/01	Olney, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Torchinsky Hebrew Funeral Home, Inc. 254 Carroll St., NW, Washington, DC 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Interstitial Pneumonitis	Weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Probable Amiodorone Reaction	Weeks
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Septic Shock

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Samuel Itscoitz	D 05568	11/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Samuel Itscoitz, M.D. 10313 Georgia Avenue, Suite 307, Silver Spring, MD 20902

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 23 2001	Geneva G. Sanders

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-6823-027
crn
Jose Antonio Arroyo

Amend Item#4c perPHYG803 1/15/02 EW
Amend Item#13,14,perPHG804 2/13/02 EW
AMEND ITEM #8, 10b&18 PER FH G803 1/08/02 jH
UNPENDED 122101:ITEMS#23a,27,28a-f per ME G802 ss

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38967

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jose Antonio Arroyo
2. Date of Death Month / Day / Year: December 02, 2001
3. Time of Death: 7:17 P.M.
4a. Facility Name *(If not institution, give street and number)*: 12376 Howard Lodge Road
4b. City, Town, or Location of Death: Sykesville
4c. County of Death: ~~Howard~~ Carroll

Funeral Director

5. Social Security Number: 220-94-7334
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 37 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 16, ~~1954~~ 1964
9. Birthplace *(State or Foreign Country)*: Lima, Peru

Usual Residence of Decedent

10a. State: Maryland
10b. County: ~~Carroll~~ HOWARD
10c. City, Town or Location: Sykesville
10d. Insida City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 12376 Howard Lodge Road
10f. Zip Coda: 21784
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Dacedant Ever in U.S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Yaar or Detas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☒ Yes 2 ☐ No *Specify:* Hispanic
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machine Operator
16b. Kind of Business/Industry: Sweetheart Cup Co.

17. Father's Name *(First, Middle, Last)*: Segundo Juan Arroyo
18. Mother's Name *(First, Middle, Maiden Surname)*: ~~Nora Quinto~~ HONORATA QUINTO

19a. Informant's Name/Relationship *(Type, Print)*: Juan Carlos Arroyo-Brother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4282 Mary Ridge Drive; Randallstown, Maryland 21133

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Pleca of Disposition *(Neme of cemetery, crematory or othar placa)*: Baltimore Wash.Crematory
Dete: 12/8/01
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Servica Licensee: [signature] M00869
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediata Cause (Final disease or condition resulting in death): a. NARCOTIC AND ETHANOL INTOXICATION
Due to (or as a consequenca of):
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Dua to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Wes case referred to medical examiner? ☒ Yes 2 ☐ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other *(Specify)* at scene
27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Sulcida 4 ☐ Homicide 5 ☐ Pending investigation 6 ☒ Could not be determined
28a. Date of Injury *(Month, Day, Year)*: Found: 12-2-01
28b. Time of Injury: Found at: 7:00p M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: Unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Found at home
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 12376 Howard Lodge Rd., Sykesville, MD

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) and menner es stated. 2 ☒ **Medical Examiner**: On the basis of examination and/or Investigation, in my opinion, death occurred et the time, date and placa, and due to the ceuse(s) and mannar stated.
29b. Signature and title of cartifier: [signature]
29c. Licansa number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: December 03, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary G. Ripple MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 06 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38968

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Handy Andrew

2. Date of Death (Month, Day, Year): December 5 2001

3. Time of Death: 8:20 AM

4a. Facility Name (If not institution, give street and number): Manor Care Health Center Rossville

4b. City, Town, or Location of Death: Rossville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215 10 2013

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 8, 1913

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1000 Franklin Avenue Apt 608

10f. Zip Code: 21221

10g. Citizen of What Country? USA

11. Meritel Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Rece - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Police Officer

16b. Kind of Business/Industry: Baltimore County Govt.

17. Father's Neme (First, Middle, Last): Harry Andrew

18. Mother's Neme (First, Middle, Maiden Surnema): Lilly Settan

19a. Informent's Neme/Reletionship (Type, Print): Jacqueline Clark-Huegel (daughter)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 54 Fox Drive Millville Delaware, 19970

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca): Parkwood Cemetery

Date: 12/8/2001

20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signature of Funeral Service Licensee:

22. Nema and Address of Facility: Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Deeth

Immediete Cause (Finel diseese or condition resulting in death): a. HEPATOCELLULAR CARCINOMA — 3 MOS.

Due to (or as a consequence of): b. LIVER CIRRHOSIS — YEARS

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

Dua to (or as a consequenca of): c.

Due to (or es a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete end piece, end due to the cause(s) and menner steted.

29b. Signetura and title of certifier: D.O.

29c. License number: H35593

29d. Date signed (Month, Dey, Year): DEC. 5, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Dr. John Loh 1124 Mace Avenue Essex, Maryland 21221

State Registrar

31. Dete filed (Month, Dey, Year): DEC 06 2001

32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Andrew, Edward 12-5-01 8:20am

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 38969

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hyon S. Adams

2. Data of Death (Month, Day, Year): December 4, 2001

3. Time of Death: 3:45 AM

4a. Facility Name (If not institution, give street and number): Stella Maris Hospice at Mercy Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 457-45-4017

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 52 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): June 9, 1949

9. Birthplace (State or Foreign Country): Korea

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Millersville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 306 Braeburn Glen Court

10f. Zip Code: 21108

10g. Citizen of What Country? Korea

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): (Unknown) Kim

18. Mother's Name (First, Middle, Maiden Surname): (Unknown)

19a. Informant's Name/Relationship (Type, Print): Chong S. Yang/ Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 306 Braeburn Glen Court Millersville Maryland 21108

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Pk.

Date: Dec 6 2001

20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Kirkley-Ruddick Funeral Home P.A. 421 Crain Highway S.E. Glen Burnie, Maryland 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic Carcinoma of the Lung — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marvin J Feldman MD Attending

29c. License number: D07930

29d. Date signed (Month, Day, Year): December 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marvin J Feldman MD 301 St Paul PL T-407 Baltimore MD 21202

State Registrar

31. Date filed (Month, Day, Year): DEC 06 2001

32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM#23a,b per phys G802 12/7/01 ss — *Certificate of Death* — Reg. No. 2001 38970

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Charles L. Austin	December 4, 2001	3:55 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1826 Norfolk Road	Glen Burnie	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-26-8493	1☒M 2☐F	71 Yrs.			Sept. 23, 1930	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Glen Burnie	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1826 Norfolk Road	21061	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Mechanic	Heating and Cooling

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Gail W. Austin	Nellie E. Ecker

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Hilda Austin / Spouse	1826 Norfolk Road, Glen Burnie Maryland 21061

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Glen Haven Mem. Park	December 7 2001	Glen Burnie, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Kirkley-Ruddick Funeral Home P.A. 421 Crain Highway S.E. Glen Burnie, Maryland 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic lung cancer	4 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D47704	12/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Trung Pham MD 795 Aquahart Rd Glenburnie MD 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 06 2001	[signature] D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

01-6834-510
mnmr
Joseph Arbaugh

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #1 PER M.E. G802 12/06/01 JH

Certificate of Death

Reg. No. 2001 38971

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH ALLEN EDWARD ARBAUGH
2. Date of Death (Month, Day, Year): December 03, 2001
3. Time of Death: 1212 pm
4a. Facility Name (If not Institution, give street and number): Johns Hopkins Hospital Bayview
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-51-9478
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 3 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 25 1998
9. Birthplace (State or Foreign Country): Elton Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10a. Street and Number: 704 S. Fagley Street
10f. Zip Code: 21224
10g. Citizen of What Country: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): n/a
16b. Kind of Business/Industry: n/a

17. Father's Name (First, Middle, Last): Kevin Eugene Arbaugh
18. Mother's Name (First, Middle, Maiden Surname): Selena Dawn Geisler

19a. Informant's Name/Relationship (Type, Print): Selena Dawn Geisler (Mother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 704 S. Fagley Street, Baltimore, Md. 21224

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Rosary Cemetery
Date: 12/08/2001
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 130 E. Fort ave. Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Smoke inhalation	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year): 12/3/01
28b. Time of Injury: 1123 HR
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Subject involved in house fire
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 704 Fagley Street Baltimore Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): December 04, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To be completed by Funeral Director. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38972

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DAHLIA MARIE AUSTIN

2. Data of Death: Month Nov Day 16 Yaar 2001

3. Time of Daath: 5:15 PM

4a. Facility Nama (If not institution, giva street and number): MEDICAL UNIVERSITY OF MARYLAND SYSTEM

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: none

6. Sex: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min. 1 30

8. Data of Birth (Month, Day, Yaar): 11/16/01

9. Birthplace (Stata or Foraign Country): Maryland

Usual Residence of Decedent

10a. Stata: MD

10b. County: Howard

10c. City, Town or Location: Elkridge

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 325 B Merle Way

10f. Zip Coda: 21075

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- It Yes, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: black

15. Decedent's Education (Specify only highast grada complatad)

Elementary/Secondary (0-12): none

College (1-4or 5+): none

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad): none

16b. Kind of Businass/Industry: none

17. Fathar's Nama (First, Middle, Last): unk

18. Mother's Name (First, Middle, Maiden Surnama): Michelle Collins

19a. Informant's Name/Ralationship (Type, Print): UMMS

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 22 S. Greene Street Baltimore, MD 21201

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☒ Othar (Specify) in state

20b. Place of Disposition (Nama of cematary, crematory or othar place):

Data:

20c. Location - City or Town, State:

21. Signature of Funaral Service Licensee: Ronald S. Wade, Director

22. Nema and Addrass of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona cause on each lina.

Approximate Intarval Between Onsat and Daath

Immediata Cause (Finat disease or condition resulting in death): a. EXTREME PREMATURITY — 30 min

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consaquance of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. It yes, outcome of pregnancy 1☐ Live birth 2☐ Fatal daath 3☐ Ectopic pregnancy 4☐ Pregnant at tima of daath 5☐ Othar (specify) 9☐ Unknown

23d. Date of dalivary: Month Day Year

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.

23a. Did tobacco usa contributa to tha causa of daath? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availebla prior to compiation of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☒ No

28. Place of Daath (Check only ona)

Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA

Othar: 4☐ Nursing Home 5☐ Rasidence 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Dete of Injury (Month, Day Yaar)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At home, farm, streat, factory, office building, atc. (Specify)

28f. Location (Street and Numbar or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, death occurred at the time, date and placa, and due to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and placa, and due to tha causa(s) and manner stated.

29b. Signature and title of certifier: Neonatologist

29c. License number: D48175

29d. Date signed (Month, Day, Year): 11/17/01

30. Nama and address of parson who completad cause of death (Item 23a) (Type, Print): Andres Rodriguez, 22 South Greene St., Baltimore, MD 21201

State Registrar

31. Data filed (Month, Day, Yaar): DEC 06 2001

32. Registrar's Signature: D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38973

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Morton Eliot Barnett

2. Date of Death (Month, Day, Year): December 02 2001

3. Time of Death: 7:30AM

4a. Facility Name (If not institution, give street and number): 7 Nightingale Way #B1

4b. City, Town, or Location of Death: Lutherville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-30-7237

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 17, 1933

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Lutherville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7 Nightingale Way #B1

10f. Zip Code: 21093

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): +4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self Employed

16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Nathan Barnett

18. Mother's Name (First, Middle, Maiden Surname): Mary Goldman

19a. Informant's Name/Relationship (Type, Print): Mrs. Joyce S. Barnett/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 Nightingale Way #B1 Lutherville, Md. 21093

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Co. | Date: 12-04-01

20c. Location - City or Town, State: Towson, Md.

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Hypertension
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Craig Gold DO

29c. License number: H53088

29d. Data signed (Month, Day, Year): December 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Craig Gold DO 1838 Greene Tree Road #135 Baltimore, Maryland 21208

State Registrar

31. Date filed (Month, Day, Year): DEC 0 6 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38974

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Franklin Newton Buck
2. Date of Death (Month, Day, Year): December 4, 2001
3. Time of Death: 5:00 AM
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Ctr.
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 232-32-6788
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 22,1929
9. Birthplace (State or Foreign Country): West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 631 South Patterson Park Ave.
10f. Zip Code: 21231
10g. Citizen of What Country?: United States
11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Exterminator
16b. Kind of Business/Industry: Pest Control
17. Father's Name (First, Middle, Last): Franklin Henry Buck
18. Mother's Name (First, Middle, Maiden Surname): Georgia Delma Nicholson
19a. Informant's Name/Relationship (Type, Print): Pearl Jones (Sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7933 St. Bridget Lane Dundalk, Maryland 21222
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Ht. of Jesus Cem.
Date: 12/6/2001
20c. Location - City or Town, State: Dundalk, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE MYOCARDIAL INFARCTION	2 HR
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CEREBROVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☑ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D47945
29d. Date signed (Month, Day, Year): DEC 4 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HARIS ALTOM 7505 OSLER DRIVE SUITE 205 TOWSON MD 21204

State Registrar

31. Date filed (Month, Day, Year): DEC 06 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38975

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY BOLD
2. Date of Death Month / Day / Year: DEC 03 2001
3. Time of Death: 11:00AM
4a. Facility Name *(If not institution, give street and number)*: Lorien Nursing Home of Mt. Airy
4b. City, Town, or Location of Death: Mt. Airy
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 219-07-5231
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept.28,1919
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Finksburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1725 Fawn Way
10f. Zip Code: 21048
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: Own home

17. Father's Name *(First, Middle, Last)*: Felix H. McKeown
18. Mother's Name *(First, Middle, Maiden Surname)*: Anna M. Yoe

19a. Informant's Name/Relationship *(Type, Print)*: Patricia B. Williams Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1725 Fawn Way, Finksburg, MD 21048

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Most Holy Redeemer Cem.
Date: 12/7/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Mark J. Deskiewicz
22. Name and Address of Facility: 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC CARCINOMA — WEEKS

Due to (or as a consequence of):
b. SUBDURAL HEMORRHAGE — WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Sjophe MD
29c. License number: D0053150
29d. Date signed *(Month, Day, Year)*: DEC 4th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHAKUNTALA GUPTA 201-109 BACK RIVER NECK RD BALTIMORE 21221

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 06 2001
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38976

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hazel Baer

2. Date of Death: Month: Dec Day: 4th Year: 2001

3. Time of Death: 1740

4a. Facility Name (If not institution, give street and number): Oak Crest Care Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-40-5020

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 27, 1915

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8800 Walther Blvd.

10f. Zip Code: 21234

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Teacher

16b. Kind of Business/Industry: Baltimore City Schools

17. Father's Name (First, Middle, Last): William Schwartz

18. Mother's Name (First, Middle, Maiden Surname): Ida Klotsch

19a. Informant's Name/Relationship (Type, Print): Mrs. Shirley Schmidt- Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5431 Pembroke Avenue Baltimore, Maryland 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery

Date: 12/8/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Heather Cain

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — Due to (or as a consequence of): — Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia, HTN, AFib, DM

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D53115

29d. Date signed (Month, Day, Year): Dec 5th 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Jeff Landsman MD 8800 Walther Blvd Parkville MD 21234

State Registrar

31. Date filed (Month, Day, Year): DEC 06 2001

32. Registrar's Signature: James D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM#9 per FH G802 12/06/01 SH

Certificate of Death

Reg. No. 2001 38977

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALBERT BUCHANAN

2. Date of Death: Month 12 Day 4 Year 01

3. Time of Death: 2:10 P.M.

4a. Facility Name (If not institution, give street and number): R.A. COWLEY SHOCK TRAUMA Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219165841

6. Sex: 1 ☑ M 2 ☐ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 5/13/25

9. Birthplace (State or Foreign Country): M.D.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 301 MCMECHEN ST.

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 43-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify: X

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MOVING/HAULING

16b. Kind of Business/Industry: MOVING

17. Father's Name (First, Middle, Last): VICTOR BUCHANAN

18. Mother's Name (First, Middle, Maiden Surname): OLLIE BROOKS

19a. Informant's Name/Relationship (Type, Print): CHARLENE HUGHES/NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 32-3 ENCHANTED HILLS RD., OWINGS MILLS, MD 21117

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST

Date: 12/11/01

20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: James A. Morton

22. Name and Address of Facility: JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Subdural Hematoma — Approximate Interval Between Onset and Death: 17 days

Due to (or as a consequence of): b. Acute Renal Failure — 3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): 11/18/01

28b. Time of Injury: 6:34PM

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred: Subject fell

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 927 N. Arlington Ave Baltimore, MD

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: P14152

29d. Date signed (Month, Day, Year): 12/4/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): N. McQuay, 22 South Greene Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 06 2001

32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38978

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
JORDAN BRENNEMAN	NOVEMBER 17 2001	1420 HRS M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
UNIVERSITY OF MARYLAND MEDICAL CENTER	BALTIMORE	BALTIMORE CITY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
none	1 [X] M 2 [ ] F	Yrs.		7 / 3 / 50	Nov 10, 2001	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Carroll	Taneytown	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13 Commerce Street	21787	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
none	none	none	none

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Roger Clark	Karen J. Brenneman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
UMMS	22 S. Greene Street Baltimore, MD 21201

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Ronald S. Wade, Director	State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. INTRACRANIAL HEMORRHAGE	3 days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. DISSEMINATED INTRAVASCULAR COAGULATION	7 days
	Due to (or as a consequence of):	
	c. SEPSIS	7 days
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [X] Yes 2 [ ] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
		1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Courtney L. Robertson MD	D0055069	11/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Courtney L. Robertson 22 South Greene Street Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 06 2001	[signature] D Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38979

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VERNETTA BROWN

2. Date of Death (Month, Day, Year): December 2, 2001

3. Time of Death: 5:04 a.m.

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 240-44-4957

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG. 5, 1933

9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1020 EDMONDSON AVENUE

10f. Zip Code: 21223

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSING AIDE

16b. Kind of Business/Industry: NURSING HOME

17. Father's Name (First, Middle, Last): DAVID BOYD

18. Mother's Name (First, Middle, Maiden Surname): LAURIA EDDINS

19a. Informant's Name/Relationship (Type, Print): GLORIA LENTON (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6408 CENTENNIAL PLACE # C GLEN BURNIE, MD 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY

Date: 12/5/01

20c. Location - City or Town, State: LANSDOWNE, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Urosepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: RES 000

29d. Date signed (Month, Day, Year): December 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeffrey Brown, MD 2401 W. Belvedere Ave, Baltimore, Maryland 21215

State Registrar

31. Date filed (Month, Day, Year): DEC 06 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Vernetta Brown

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38980

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MILDRED BAUCOM
2. Date of Death Month Day Year: November 23 2001
3. Time of Death: 10:50 AM
4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL 5601 Loch Raven Blvd
4b. City, Town, or Location of Death: Baltimore, MD 21239
4c. County of Death:

Funeral Director

5. Social Security Number: 244-26-8401
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 15, 1914
9. Birthplace (State or Foreign Country): unk

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4700 Harford Avenue
10f. Zip Code: 21214
10g. Citizen of What Country? USA

11. Marital Status: unk — 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unk; College (1-4or 5+): unk
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk
16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): unk
18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): Good Samaritan Hospital
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5601 Loch Raven Blvd Baltimore, MD 21239

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☒ Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Septic shock
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Urosepsis
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnent in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnency 4☐ Pregnent at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivary Month Day Year

Part II. Other **significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
a. flutter with Rapid ventricular rate

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one) — Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: , MD
29c. License number: P12561
29d. Date signed (Month, Day, Year): November/23/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Maryam Zomanian, MD Good Samaritan Hospital 5601 Loch Raven Blvd Baltimore, MD 21239

State Registrar

31. Date filed (Month, Day, Year): DEC 06 2001
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #8 PER FH G802 12/06/01 JH

Certificate of Death

Reg. No. 2001 38981

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
LULA BRINSON			Dec. 3rd 2001	10:00 AM
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death		
1620 N. BENTALOU STREET	BALTIMORE	NA		

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
254-01-1550	1☐M 2☒F	101 Yrs.			MAR. 16, 1901 ~~1900~~	GA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1620 N. BENTALOU STREET	21216	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6th	0	DOMESTIC	HOMES

17. Father's Name (First, Middle, Last)	16. Mother's Name (First, Middle, Maiden Surname)
GEORGE EDENFIELD	MARY EDENFIELD

19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
NATALIE JOHNSON (GOD-DAUGHTER)	3903 SADIE ROAD RANDALLSTOWN, MD 21133

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	ARBUTUS MEMORIAL PK.	12/7/01	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. HEART FAILURE	YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. AORTIC STENOSIS	YEARS
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☑ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D 15480	Dec 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL ZIMRING MERCY MEDICAL CENTER, BALT, MD 21202

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 06 2001	[signature] D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

01-6827-510
crm
Wendell P. Baines

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM #5 PER FH G802 2/21/02 FH
AMENDED ITEM#10e per fh G802 122701 ss
UNPENDED 122701:ITEMS#23a,27 per ME G802 sss

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2001 38982

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WENDELL P. BAINES
2. Date of Death Month / Day / Year: December 03, 2001
3. Time of Death: 7:45 A.M.
4a. Facility Name *(If not institution, give street and number)*: 4016 Penhurst Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 514-88-6000
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 37 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: NOV. 2, 1964
9. Birthplace *(State or Foreign Country)*: VA

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4016 ~~4616~~ PENHURST AVENUE
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yas 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Rece - American Indian, Black, White, etc. *Specify:* AFRICAN AMERICAN

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DEPT. OF HUMAN RESOURCES
16b. Kind of Business/Industry: DATA SPECIALIST

17. Father's Name *(First, Middle, Last)*: LIMON SYKES
18. Mothar's Name *(First, Middle, Maiden Surneme)*: JOYCE WILLIAMS

19a. Informant's Name/Relationship *(Type, Print)*: KATURA O. COLEMAN (SISTER)
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3731 CRESTFIELD CT. BALTIMORE, MD 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, crametory or other piece)*: POST CEMETERY
Dete: 12/10/01
20c. Location - City or Town, State: FT. BRAGG, NC

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Addrass of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death): a. HYPERTENSIVE HEART DISEASE
Due to (or as a consequence of):
Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest: b.
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributs to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [X] Other *(Specify)* at scene

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
26d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Routa Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) end manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Theodore M. Kiz
29c. Licensa number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: December 04, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE Mikiz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 0 6 2001
32. Registrar's Signature: [signature] G. Sparks

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38983

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EDWARD CONLEY

2. Date of Death Month Day Year: November 25, 2001

3. Time of Death: 7:00 PM

4a. Facility Name *(If not institution, give street and number)*: LORIEN NURSING HOME

4b. City, Town, or Location of Death: COLUMBIA

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 577-16-5677

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: AUG. 26, 1923

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: PRINCE GEORGE

10c. City, Town or Location: LAUREL

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1100 MONTROSE AVENUE

10f. Zip Code: 20707

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SALESMAN

16b. Kind of Business/Industry: DAIRY

17. Father's Name *(First, Middle, Last)*: EDWARD SHARPE CONLEY, SR.

18. Mother's Name *(First, Middle, Maiden Surname)*: LILLIAN RHODES

19a. Informant's Name/Relationship *(Type, Print)*: OMELIA R. CONLEY/WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1100 MONTROSE AVENUE, LAUREL, MARYLAND 20707

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MT. OLIVET CEMETERY

Date: 11/30/01

20c. Location - City or Town, State: WASHINGTON, DC

21. Signature of Funeral Service Licensee: M.K. Mustaly

22. Name and Address of Facility: FLECK FUNERAL HOME, INC.. 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PANCREATIC CANCER — MONTHS

Due to (or as a consequence of):

b. DIABETES MELLITUS — MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. ANEMIA — MONTHS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gupta MD

29c. License number: D0053150

29d. Date signed *(Month, Day, Year)*: NOV 29TH 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHAKUNTALA GUPTA 201-109 BACK RIVER NECK RD BALTIMORE 21221

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 06 2001

32. Registrar's Signature

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

RR 10+1

RR

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38984

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Delbert Leslie Crawford	Dec. 3, 2001	1700 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Laurel Regional Hospital	Laurel	Prince George's

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213.22.1485	XX 1 M 2 F	76 Yrs.			August 3, 1925	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	Laurel	1 ☐ Yes 2 ☒ No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
14819 Belle Ami Drive	20707	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	Water Treatment Engineer	U. S. Government

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surname)
Franklin Crawford	Hilda Reigle

19a. Informant's Neme/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Scott Edwards - nephew	7962 Telegraph Road, Severn, Md. 21144

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)	Ft. Lincoln Cem.	12/8/01	Brentwood, Md.

21. Signature of Funeral Service Licensee ▶ Alan M. Fleck

22. Neme and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Rd., Laurel, Md. 20707

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Endocarditis	Days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	b. Staphyccoccus Aurens Sepsis	Days
	Due to (or as a consequence of):	
	c. Embolic Cerebrovascular Accident	Days
	Due to (or as a consequence of):	
	d.	

RR

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown	1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 ☐ Yes 2 ☒ No	Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	
	26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner es stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D42110	DECEMBER 3 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
D. L. GRIFFEN III 7350 VAN DUSEN ROAD LAUREL, MARYLAND 20707

RR 10-4

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 0 6 2001	▶ Regina D Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38985

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cynthia Marie Cozart

2. Date of Death (Month, Day, Year): December 5, 2001

3. Time of Death: 8:00am

4a. Facility Name (If not institution, give street and number): Gilcrest Nursing & Hospice Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-64-2453

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 01, 1955

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: ☒ 1 Yes 2☐ No

10e. Street and Number: 405 N. Chester Street

10f. Zip Code: 21231

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+): 3yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Postal Clerk

16b. Kind of Business/Industry: Postal Service

17. Father's Name (First, Middle, Last): Albert Lee Carrington

18. Mother's Name (First, Middle, Maiden Surname): Ola B. Robinson

19a. Informant's Name/Relationship (Type, Print): Ceceilia C. Miller (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 25 N. Ellwood Avenue Balto, MD. 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park

Date: 12/11/01

20c. Location - City or Town, State: Randallstown, MD.

21. Signature of Funeral Service Licensee: Dennis B Caple

22. Name and Address of Facility: Dennis B. Caple Funeral Home 5502 Winner Avenue Baltimore, MD. 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. lung cancer — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D0051926

29d. Date signed (Month, Day, Year): December, 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen M. Gordon 6565 N. Charles St, Baltimore MD 21204

State Registrar

31. Date filed (Month, Day, Year): DEC 06 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Compart, Cynthia Dec 5, 2001 8am

X

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38986

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Hammond Carr
2. Date of Death (Month, Day, Year): December 5, 2001
3. Time of Death: 2:30 AM
4a. Facility Name (If not institution, give street and number): Roland Park Place
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 216-46-2633
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 96 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06/27/1905
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: MD
10b. County: n/a
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 830 West 40th Street Unit 716
10f. Zip Code: 21211
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Harry G. Hammond
18. Mother's Name (First, Middle, Maiden Surname): Mollie Roth

19a. Informant's Name/Relationship (Type, Print): Barbara Ann Spicer/Atty.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9515 Deerco Road Suite 902 Timonium, Maryland 21093

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp. | Date: 12/06/2001
20c. Location - City or Town, State: Towson, Maryland 21204

21. Signature of Funeral Service Licensee: Stephen D. Coster
22. Name and Address of Facility: Ruck Towson Funeral Home,. Inc. 1050 York Road Towson, Maryland 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. MYOCARDIAL INFARCTION — 3 HRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CARCINOMA OF COLON
TOTAL H.P. REPLACEMENT (1/2001)

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D12399
29d. Date signed (Month, Day, Year): December 5, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): CHARLES D. DONOVAN JR 6366 N. CHARLES ST. #518 BALTIMORE MD 21204

State Registrar

31. Date filed (Month, Day, Year): DEC 06 2001
32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38987

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
ALLEN	CULLING	CLARK	DECEMBER 5, 2001	3:34 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
GREATER BALTIMORE MEDICAL CENTER	TOWSON	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplace (State or Foreign Country)
578-22-0730	1 [X] M 2 [ ] F	77 Yrs.			Apr. 27, 1924	Washington DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Baltimore	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6302 N. Charles St.	21212	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Investor	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Henry Woodman Clark	Beatrice Edwina Shaw

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Dorothy C. Graul/daughter	909 Malverne Ave. Towson, MD 21204

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Rock Creek Cemetery	12/8/01	Washington D. C.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 21204

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Clark - Allen

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	C.R-F	> 2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): b.	End stage Renal disease	> 2 years
Due to (or as a consequence of): c.	HTN	> 2 years
Due to (or as a consequence of): d.	C-A-S	> 2 years

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [X] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
	D42736	12-5-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
AYMAN F. AKKAD, MD, 7600 OSLER DR, #411, TOWSON, MD 21204

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
DEC 06 2001	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38988

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Martha T. Capobianco
2. Date of Death (Month, Day, Year): December 3, 2001
3. Time of Death: 8:00 PM
4a. Facility Name *(If not institution, give street and number)*: Stella Maris
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-40-0861
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: January 16, 1914
9. Birthplace *(State or Foreign Country)*: Germany

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5402 Catalpha Road
10f. Zip Code: 21214
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home Maker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Philip Hauf
18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Raaf

19a. Informant's Name/Relationship *(Type, Print)*: Ronald Capobianco - Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6705 Belair Rd. Baltimore, MD 21206

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, cremetory or other place)*: Hilltop Service
Date: 12/7/01
20c. Location - City or Town, State: Towson, MD

21. Signature of Funeral Service Licensee: ▶ David L. Hartack Jr.
22. Name and Address of Facility: Baltimore, Maryland 21214 — Leonard J. Ruck, Inc. 5305 Harford Rd.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar tha moda ot dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediata Causa (Final diseasa or condition resulting in death)
a. Congestive Heart Failure.
Due to (or as a consequence of):
b. Severe Mitral Regurgitation

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last
Due to (or as e consequance of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to complation of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, straat, factory, offica building, etc. *(Specify)*
28f. Location *(Straat and Number or Rural Route Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledga, deeth occurred at the time, date and piece, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, daath occurred et tha time, data end ptace, and due to tha cause(s) and manner stated.

29b. Signatura and titla of certifiar: ▶ Linda H Morris MD
29c. Licansa number: D0018406
29d. Date signed *(Month, Day, Year)*: 12-05-01

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print): FRANK MORRIS 7505 OSLER DR TOWSON MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 06 2001
32. Registrar's Signature: Denise D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for usa as tha burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38989

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Christopher M. Christensen
2. Date of Death (Month, Day, Year): November 30, 2001
3. Time of Death: 1926 M
4a. Facility Name (If not institution, give street and number): 2507 Amber Orchard Ct. #102
4b. City, Town, or Location of Death: Odenton
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 566-40-2905
8. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 24, 1932
9. Birthplace (State or Foreign Country): Iowa

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Odenton
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No XX
10e. Street and Number: 2507 Amber Orchard Ct. #102
10f. Zip Code: 21113
10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bank Officer
18b. Kind of Business/Industry: Banking

17. Father's Name (First, Middle, Last): Ansgar Christensen
18. Mother's Name (First, Middle, Maiden Surname): Alice Rasmussen

19a. Informant's Name/Relationship (Type, Print): Jon Christensen / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1019 1rst Street Glen Burnie, Maryland 21060

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem. Park
Date: December 5 2001
20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: Lou L. Ebaugh
22. Name and Address of Facility: Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Arteriosclerotic Heart Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28e. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William P. Jones Deputy
29c. License number: D 06054
29d. Date signed (Month, Day, Year): 12/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones, MD 695 America Ct. 21035

State Registrar

31. Date filed (Month, Day, Year): DEC 06 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38990

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARIE COHEN
2. Date of Death (Month Day Year): DECEMBER 1,2001
3. Time of Death: 11:20 PM
4a. Facility Name (If not institution, give street and number): 725 MT. WILSON LANE #622
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 391-18-3929
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT.15,1908
9. Birthplace (State or Foreign Country): S.C.

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 725 MT. WILSON LANE #622
10f. Zip Code: 21208
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): BENJAMIN PATZ
18. Mother's Name (First, Middle, Maiden Surname): YETTA FLEISHMAN

19a. Informant's Name/Relationship (Type, Print): ELAINE WURZEL / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 25 WOODLAND DRIVE - SANDS POINT, NY 11050

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BETH TFILOH CEMETERY
Date: 12/5/01
20c. Location - City or Town, State: WOODLAWN, MD

21. Signature of Funeral Service Licensee: ▶ Edward C. Rund
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — 3 days
Due to (or as a consequence of):
b. atherosclerotic Cardiovascular Disease — 5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Part tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D38675
29d. Date signed (Month, Day, Year): 12/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOEL MESHULAM 301 ST PAUL PL SUITE 605 BALTIMORE MD 21202

State Registrar

31. Date filed (Month, Day, Year): DEC 06 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-6815-510
B.K.S
DONNA CALLAWAY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 010902:items323a,ptII,27,28a-f per ME G803 ss *Certificate of Death*

Reg. No. 2001 38991

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donna Sue Callaway
2. Date of Death (Month, Day, Year): DEC. 2, 2001
3. Time of Death: 12:45 PM
4a. Facility Name (If not institution, give street and number): UNION MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-46-0936
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 55 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 23, 1946
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 853 W. 36th Street 2nd Floor
10f. Zip Code: 21211
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Clarence Wees
18. Mother's Name (First, Middle, Maiden Surname): Ruby Taylor

19a. Informant's Name/Relationship (Type, Print): Tanya Kotschenreuther Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 171 Chapeltown Circle Baltimore Maryland 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crest Lawn Memorial
Date: 12/6/01
20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funeral Service Licensee: Lynn B. Henss
22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 21211
3631 Falls Road, Baltimore, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. HEAD AND CHEST INJURIES
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSIVE CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year): 12-2-01
28b. Time of Injury: Unknown M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Subject fell down steps
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Residence
28f. Location (Street and Number or Rural Route Number, City or Town, State): 853 W. 36th St., Baltimore, MD

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): DEC. 3, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary G. Ripple M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 0 6 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38992

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MAEBEL WILSON DOWNS
2. Date of Death (Month, Dey, Year): December 2 2001
3. Time of Death: 4:30am
4a. Facility Name (If not institution, give street and number): STELLA MARIS-DULANEY
4b. City, Town, or Location of Death: TIMONIUM
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 242-44-9618
6. Sex: 1☐ M 2☒F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): OCT 16 1922
9. Birthplace (State or Foreign Country): SOUTH CAROLINA

Usuet Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 827 N. ARLINGTON TERRACE APT 114
10f. Zip Code: 21217
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 yrs | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC
16b. Kind of Business/Industry: FAMILY CARE

17. Father's Name (First, Middle, Last): WILL WILSON
18. Mother's Name (First, Middle, Meiden Surneme): SALLY WILSON

19a. Informant's Name/Relationship (Type, Print): Sheila Y. Brutus/Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 11463 SToney Point Place, Germantown, Md., 20876

20e. Method of Disposition: 1☐ Buriat 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other pleca): METRO CREMATORY
Date: 12-5-01
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Charles V. Brown
22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. GASTRIC CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Othar (Specify) HOSPICE

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D43725
29d. Dete signed (Month, Day, Year): 12/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed (Month, Day, Year): DEC 0 6 2001
32. Registrar's Signature: Deputy B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DECEMBER 2, 2001 4:30 a.m.
Baltimore, Maryland 21215-0020

MAEBEL DOWNS
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 38993

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: VIOLA V. ECK
2. Date of Death Month Day Year: December 3, 2001
3. Time of Death: 9:16 AM
4a. Facility Name *(If not institution, give street and number)*: St. Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-01-9774
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 9, 1913
9. Birthplace *(State or Foreign Country)*: MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1055 W. Joppa Rd. Apt. 718
10f. Zip Code: 21204
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Self Employed
16b. Kind of Business/Industry: Retail

17. Father's Name *(First, Middle, Last)*: Andrew P. Eck
18. Mother's Name *(First, Middle, Maiden Surname)*: Edna I. Russell

19a. Informant's Name/Relationship *(Type, Print)*: Holly Kahler/niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 357 W. Exeter St. Satellite Beach, FL 32937

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Druid Ridge Cemetery
Date: 12/7/01
20c. Location - City or Town, State: Pikesville, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Cardiomyopathy
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D-12849
29d. Date signed *(Month, Day, Year)*: 12-6-01
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): A.H. GHILADI, M.D. 7600 OSLER Dr. TOWSON, Md 21204

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 06 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Viola V. Eck Dec. 3, 2001 9:16 AM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38994

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT BRUCE ELDER
2. Date of Death (Month, Day, Year): NOVEMBER 28, 2001
3. Time of Death: 3:30 AM
4a. Facility Name (If not institution, give street and number): 130 Spa View Avenue
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 094-24-1968
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 25, 1929
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 130 Spa View Avenue
10f. Zip Code: 21401
10g. Citizen of What Country?: USA

11. Maritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorcad
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: '46-49
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): oceanographer
16b. Kind of Business/Industry: aquatic

17. Father's Name (First, Middle, Last): Eugene Everett Elder
18. Mother's Name (First, Middle, Maiden Surname): Ione Frederick

19a. Informant's Name/Relationship (Type, Print): Mary Ann Elder/spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 130 Spa View Avenue Annapolis, MD 21401

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Placa of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Colon cancer — 4 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Ware autopsy findings aveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signeture and title of certifier: Elaine Werner MD
29c. License number: D52830
29d. Date signed (Month, Day, Year): November 29, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elaine Werner 900 Bestgate Rd #320, Annapolis, MD 21401

State Registrar

31. Date filed (Month, Day, Year): DEC 06 2001
32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #5 PER FH G802 12/06/01 JH

Certificate of Death

Reg. No. 2001 38995

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
PERNELLA L. FLEMING	11	30	2001	4:50 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MARYLAND BAPTIST NURSING HOME	BALTIMORE	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-16-0044 ~~212-160044~~	1☐ M 2☒ F	84 Yrs.					AUG. 12, 1917	NC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	BALTIMOR	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2601 ALLENDALE ROAD	21216-	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th	0	BEAUTICIAN - COSMETICS	BEAUTY SALON

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JAMES STANTON	GERLENE STATON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CHESTER FLEMING JR. (SON)	5805 PARK HEIGHTS AVENUE BALTIMORE, MD 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	GARRISON FOREST CEM.	12/06/01	OWINGS MILLS, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac arrythmia	10 mins
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Atherosclerotic heart disease	5 yrs
	c. Due to (or as a consequence of): congestive Heart failure	11
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown	1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D 30494	12/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DESAI MD 4660 Wilkens Ave Catonsville MD 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 06 2001	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38996

NAME KNOWN TO PHYCISIAN: gilliam,overton

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Overton Willie Gilliam		2. Date of Death (Month, Day, Year): DECEMBER 3, 2001	3. Time of Death: 7:15 A.M.
4a. Facility Name *(If not institution, give street and number)*: VA MARYLAND HEALTH CARE SYSTEM	4b. City, Town, or Location of Death: PERRY POINT	4c. County of Death: CECIL	
5. Social Security Number: 124-01-7541	6. Sex: 1☒ M 2☐ F	7. Age *(In yrs. last birthday)*: 93 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.	8. Date of Birth *(Month, Day, Year)*: Jan 28, 1908
9. Birthplace *(State or Foreign Country)*: Virginia			

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4409 Old York Road	21212	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Yaar or Datas:	1☐ Yes 2☒ No *Specify:*	*Specify:* Black

15. Decedent's Education *(Specify only highest grada completed)*		16a. Decedent's Usuei Occupation *(Give kind of work done during most of working life. DO NOT use retired)*	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
10th		Elavator Operator	U.S. Gov't

17. Father's Neme *(First, Middle, Last)*	18. Mother's Neme *(First, Middle, Meiden Surnema)*
Willie Herbert Gilliam	Mary Marie Gilliam

19a. Informent's Name/Relationship *(Type, Print)*	19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*
Joycene Cherry Dade (Daug)	9185 Hitching Post Lane Laurel, MD 20723

20a. Method of Disposition	20b. Piece of Disposition *(Name of cemetery, crematory or other place)*	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removei from Stete 4☐ Donation 5☐ Other *(Specify)*	MD. National Mem PK	12/07/01	Laurel, Maryland

21. Signature of Funerel Service Licensee	22. Name end Address of Facility
▶ Dennis B. Caple	Dennis B. Caple Funeral Home 5502 Winner Avenue Baltimore, MD. 21215

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line.

		Approximete Interval Between Onset end Death
Immediete Cause (Final disease or condition resulting in death)	e. ASPIRATION PNEUMONIA	2 WEEKS
	Due to (or es e consequence of):	
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last	b.	
	Due to (or es a consequence of):	
	c.	
	Dua to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes case referred to medical examiner?	26. Place of Death *(Check only one)*
1☐ Yes 2☒ No	Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death	28a. Dete of Injury *(Month, Dey Year)*	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*			28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*

1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and menner as stated.

2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and menner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed *(Month, Day, Year)*
▶ S. Sodhi	D42014	DECEMBER 3, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

SURINDERPAL SODHI, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD, 21902

State Registrar

31. Date filed *(Month, Day, Year)*	32. Registrar's Signeture
DEC 06 2001	Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38997

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as above.

1. Decedent's Name (First, Middle, Last): Mary Joyce Gillin		2. Data of Death: Month November Day 29, Year 2001	3. Time of Death: 4:30 a M
4a. Facility Name (If not institution, give street and number): 254 Waxter Way	4b. City, Town, or Location of Daath: Baltimore City	4c. County of Death:	
5. Social Security Number: 215-28-4323	6. Sex: 1☐M 2☒F	7. Aga (In yrs. last birthday): 70 Yrs.	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): April 5, 1931	9. Birthplace (State or Foreign Country): Maryland		

Usual Residence of Decedent

10a. State: Maryland	10b. County:	10c. City, Town or Location: Baltimore City	10d. Insida City Limits: 1☒Yas 2☐No
10a. Street and Number: 254 Waxter Way		10f. Zip Coda: 21217	10g. Citizan of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	12. Was Decedent Evar in U.S. Armed Forcas? 1☐Yas 2☒No If Yes, Give Year or Datas:	13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐Yas 2☒No Specify:	14. Race - Americen Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):	16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Office Manager	16b. Kind of Businass/Industry: Manufacturer	
17. Father's Name (First, Middle, Last): John B. Thompson	18. Mother's Name (First, Middla, Meiden Surname): Jean Kerner		
19a. Informant's Name/Relationship (Type, Print): James M. Gillin (Husband)	19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, State, Zip Code): 254 Waxter Way, Baltimore, Maryland 21217		
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from Stata 4☐Donation 5☐Other (Specify)	20b. Place of Disposition (Nama of cemetery, crematory or othar place): Loudon Park Cemetery	Data: 12/1/01	20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee:	22. Name and Address of Facility: Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229		

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Metastatic breast cancer — Due to (or as a consequence of): — 4 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown	23c. If yes, outcoma of pregnancy 1☐Live birth 2☐Fetal daath 3☐Ectopic pregnancy 4☐Pregnant at time of deeth 5☐Other (specify) 9☐Unknown	23d. Data of dalivary Month Day Year

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause givan in Part I.

23a. Did tobacco use contribute to the cause of daath? 1☐Yas 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of causa of daath? 1☐Yas 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Othar: 4☐Nursing Home 5☒Rasidanca 6☐Othar (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Yaar)	28b. Time of Injury M	28c. Injury at Work? 1☐Yas 2☐No	28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)			28f. Location (Street and Numbar or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, daath occurred at the tima, data and place, and due to the cause(s) and mannar as stated. 2☐Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, daath occurred at the tima, data and placa, and due to tha ceuse(s) and manner stated.

29b. Signature and title of certifier: Richard L. Haslic MD	29c. Licensa number: D36814	29d. Data signed (Month, Day, Year): 11/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard L. Haslic MD 7505 Osler Dr. Suite 302 Towson MD

State Registrar

31. Date filed (Month, Day, Year): DEC 06 2001	32. Registrar's Signature: Deputy G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 38998

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harry Thomas Gott

2. Data of Death Month Day Year: Dec. 03, 2001

3. Time of Death: 11:40A M

4a. Facility Name (If not institution, give street and number): Civista Medical Center

4b. City, Town, or Location of Death: La Plata

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 217-12-0849

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yeer): Aug. 20, 1908

9. Birthplace (State or Foraign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Clinton

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8600 Mike Shapiro Drive Apt. 514

10f. Zip Code: 20735

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 4 yrs.

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa retired): Gardener / Maintenance

18b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): John T. Gott

18. Mother's Name (First, Middle, Maiden Surname): Eva M. Bowen

19a. Informant's Name/Relationship (Type, Print): Mrs. Mary G. Lynch / Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda): 12650 Norwood Drive Charlotte Hall, MD 20622

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Nama of cematary, crematory or othar place): Holy Cross Cemetery

Date: Dec. 6, 2001

20c. Location - City or Town, State: Brooklyn, Maryland

21. Signature of Funeral Service Licensee: Michael E. Canapp

22. Nama and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, MD 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the moda ot dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each lina.

Approximate Intarval Batwaen Onsat and Daath

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory Insufficiency

Dua to (or as a consequence of):

b. Acute Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcoma of pregnancy 1 [ ] Live birth 2 [ ] Fatal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at tima of deeth 5 [ ] Othar (specify) 9 [ ] Unknown

23d. Deta of dalivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

Chronic Lymphocytic Leukemia, Anemia Coronary Artery Disease, Cardiac Arrythmias

23a. Did tobacco use contribute to tha causa of daath? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Ware autopsy findings available prior to completion of causa of daath? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Daath (Check only ona)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Dascribe how injury occurred

28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Straat and Numbar or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledga, daath occurred at the tima, data and place, and due to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurrad at the tima, data and place, and due to tha cause(s) and mannar stated.

29b. Signature and title of certifier: M.D.

29c. Licensa number: D28035

29d. Data signed (Month, Day, Year): 12-3-01

30. Name and address of person who completed cause of death (Item 23a) (Typa, Print): Basirmohmad F. Kolia, MD 9135 Piscataway Rd, Ste 210, Clinton, MD 20735

State Registrar

31. Data filed (Month, Day, Year): DEC 06 2001

32. Registrar's Signatura: D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Harry Gott

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 38999

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DALLAS LEE HANSEN
2. Dete of Deeth Month Day Year: December 3, 2001
3. Time of Death: 6:00 PM
4e Facility Neme *(If not institution, give street and number)*: 615 Chestnut Ave. Apt. 1214
4b. City, Town, or Location of Deeth: Towson
4c. County of Death: Baltimore

Funeral Director

5. Sociel Security Number: 216-16-2139
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: July 26, 1922
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 615 Chestnut Ave. Apt. 1214
10f. Zip Code: 21204
10g. Citizen of What Country?: USA

11. Maritel Status: 1☐Never Merried 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent ot Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 1
16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Home maker
16b. Kind of Business/Industry: Own home

17. Father's Neme *(First, Middle, Last)*: Herbert Clayton Estep
18. Mother's Neme *(First, Middle, Maiden Surname)*: Anna Belle Prout

19a. Intormant's Name/Reletionship *(Type, Print)*: Mrs. Polly G. Cloude/daughter
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 266 Waterway Rd. Oxford, PA 19363

20a. Method of Disposition: 1☐Burial 2☒Cremetion 3☐Removel from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, crematory or other piece)*: Hilltop Service Corp.
Date: 12/5/01
20c. Location - City or Town, State: Towson, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode ot dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediete Cause (Final diseese or condition resulting in deeth)
a. Respiratory Failure
Due to (or as a consequence of):
b. Chronic Obstructive Pulmonary Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Malnutrition, Status post Gastrectomy, ASCVD

23b. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings eveileble prior to completion of cause ot death? 1☐Yes 2☑No

25. Wes case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death *(Check only one)*: Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☑Residence 6☐Other *(Specify)*

27. Menner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time ot Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, tactory, office building, etc. *(Specify)*
28t. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and manner as stated. 2☐**Medicat Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: W.W Wilson M.D
29c. License number: D41476
29d. Dete signed *(Month, Day, Year)*: 12.04.2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAYMOND W. WILSON M.D. 6565 N. Charles St. Suite 416, Baltimore MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 06 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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Dallas Hansen Dec. 3, 2001 6:00 PM

#

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM#30 per DVR G802 120601 ss — *Certificate of Death* — Reg. No. 2001 39000

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month / Day / Year	3. Tima of Death
Daniel Roe Hanna	DECEMBER 4, 2001	4:13PM

4a. Facility Nama (If not institution, giva street and number)	4b. City, Town, or Location of Daath	4c. County of Death
GREATER BALTIMORE MEDICAL CENTER	TOWSON	BALTIMORE

Funeral Director

5. Social Security Numbar	6. Sex	7. Aga (In yrs. last birthday)	If Undar 1 Year: Months / Days	If Undar 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (Stata or Foraign Country)
219-05-6348	1☒ M 2☐ F	80 Yrs.			3-19-1921	MD

Usual Residence of Decedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Insida City Limits
MD	Baltimore	Sparks	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Coda	10g. Citizen of What Country?
1208 Belfast Road	21152	USA

11. Marital Status	12. Was Decedant Evar in U.S. Armed Forcas?	13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.)	14. Race - Amarican Indian, Black, White, atc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yas 2☐ No If Yes, Giva Yaar or Datas: WW II	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedant's Education (Specify only highast grade compiatad)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired)	18b. Kind of Businass/Industry
Elementary/Secondary (0-12)	Collega (1-4or 5+)		
12	2	Sales	Hutzler Brothers

17. Fathar's Name (First, Middle, Last)	18. Mother's Name (First, Middla, Maidan Surname)
Roe Hanna	Helen L. Justice

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda)
Jane C. Hanna	1208 Belfast Road Spark MD 21152

20a. Method of Disposition	20b. Placa of Disposition (Name of cemetery, crematory or other place)	Data	20c. Location - City or Town, Stata
1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)	Bosley Cemetery	12/9/01	Cockeysville, MD

21. Signatura of Funeral Service Licensee	22. Name and Address of Facility
▶ Kan B Eline	11824 Reisterstown Road Eline Funeral Home Reisterstown , MD 21136

Physician /Medical Examiner

23a. Part I. Enter tha disease, or complications that caused the daath. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only ona causa on aach lina.

Approximata Intarval Batwaan Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute MI c Cardiogenic shock — Dua to (or as a consequence of):

b. ASCVD S/P CABG — Dua to (or as a consequence of): — 20 yrs

Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

c. — Dua to (or as a consaquance of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcoma of pregnancy	23d. Data of dalivary Month / Day / Year
1☐ Yas 2☐ No 9☐ Unknown	1☐ Liva birth 2☐ Fatal daath 3☐ Ectopic pregnancy 4☐ Pregnant at tima of daath 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to daath but not rasulting in the underlying cause given in Part I.

Diabetes Type II — hypothyroidism — HTN — Peripheral Vasc. Disease — ↑ Cholesterol

23a. Did tobacco use contributa to tha causa of death?	24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to complation of causa of daath?
1☐ Yas 2☐ No 3☐ Probably 4☐ Unknown	1☐ Yas 2☒ No	1☐ Yas 2☐ No

25. Was case referrad to medical axaminer?	26. Placa of Daath (Check only ona)	
1☐ Yas 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Othar: 4☐ Nursing Homa 5☐ Rasidance 8☐ Other (Specify)

27. Manner of Daath	28a. Date of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☐ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined		M	1☐ Yas 2☐ No	

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Straat and Number or Rural Routa Numbar, City or Town, State)

29a. Certifier (Check only ona) — 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha time, data and placa, and due to the causa(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manaar stated.

29b. Signature and title of certifier	29c. License numbar	29d. Data signed (Month, Day, Yaar)
▶ Mark S Kaplan MD	D19155	12/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark S. Kaplan Greater Baltimore Medical Center, Baltimore County, Maryland

State Registrar

31. Date filed (Month, Day, Yaar)	32. Registrar's Signatura
DEC 06 2001	▶ Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

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Hanna, Daniel

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all